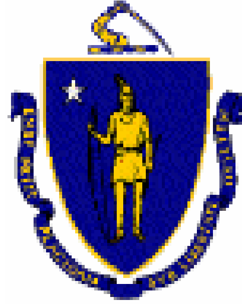

Joint Committee on
Mental Health and Substance Abuse

2005-2006 Biennial Report

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RUTH B. BALSER
HOUSE CHAIR

STEVEN A. TOLMAN
SENATE CHAIR

THE COMMONWEALTH OF MASSACHUSETTS
JOINT COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE

2005-2006

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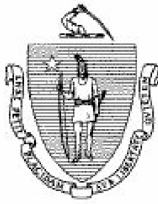

The Commonwealth of Massachusetts
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December 2006

Dear Colleagues:

The Joint Committee on Mental Health and Substance Abuse was established at the start of the 2005-2006 legislative session as part of a re-organization of the legislature's committee structure. By establishing the Committee, the legislature made an historic commitment to critical areas of health care that had previously all too frequently been neglected. As Committee Chairs, we are very pleased to report that the Committee has had tremendous success educating members of the legislature and the public, achieving a significant expansion of services, and launching several new initiatives.

The Committee considered bills that looked at many aspects of the two illnesses of mental health and substance abuse such as, without limitation: insurance coverage, criminal justice and public safety, housing and homelessness, reimbursement and licensing for providers, civil commitment and court hearings, residential and day medical services, medication, education of the public, and guardianship. Additionally, early in the term the Committee conducted two informational hearings (one focused on mental health, the other on addictions) in order to educate the members of the Committee. Later in the term, the Committee held four oversight hearings for the purpose of assessing the access to and quality of mental health services for several populations: children, incarcerated individuals, and Medicaid recipients. Further, an oversight hearing was held to assess the impact on access five years after passage of the Massachusetts Parity Act. Finally, a Sub-Committee focused on alcoholism was established under the leadership of House Vice-Chairwoman Liz Malia.

The greatest achievements for the Committee were the increase in public funding for the mental health and substance abuse programs of the Commonwealth and the protection of insurance coverage for the treatment of mental illness and addictions in the landmark health care reform legislation enacted this session. The Committee worked closely with many consumers, providers, and advocates who taught us a great deal and who share in our successes.

We believe that the Joint Committee on Mental Health and Substance Abuse has had a successful beginning. We hope that this report will inform you not only of those successes but will also indicate that there is work still ahead in order for Massachusetts to have a world class system of care for those who live with the challenges of mental illness and/or addictions.

RUTH B. BALSER
House Chair

STEVEN A. TOLMAN
Senate Chair

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Legislative Accomplishments

The most significant legislative accomplishments for the Joint Committee on Mental Health and Substance Abuse occurred in the context of the budget and the landmark health care reform legislation. Below is a summary of these accomplishments.

Budget

The Joint Committee on Mental Health and Substance Abuse worked closely with both the House and Senate Ways and Means Committees. As a result, this year's budget (including both the FY '06 supplemental and the FY'07 budget) included the strongest mental health and substance abuse budget in years.

Budget Success Highlights: (For complete description of increases in funding to mental health and substance abuse programs, see pages 3- 8)

- The FY '06 Supplemental Budget includes an increase of $21 million dollars in funding for the Bureau of Substance Abuse Services. The $21 million appropriation includes funds for the establishment of sobriety high schools, an increase in rates for recovery homes, and the placement of substance abuse counselors at houses of corrections.

- The FY'07 budget contains a new line item for the Bureau of Substance Abuse Services with an appropriation of $5 million for step down services for individuals coming out of detox.

- A top priority for the Committee was the diversion of mentally ill and addicted individuals from the criminal justice system. The FY '07 budget includes $500,000 to create a new grant program to establish jail diversion programs in 5 communities as well as a grant to support the existing program in Framingham. Additionally, the juvenile court clinics received new funding.

- An additional concern has been the mentally ill population that faces homelessness. One of the budget increases was a housing program for the homeless mentally ill.

- In response to an outcry from consumers and providers of behavioral health care protesting the shifting of individuals covered by MassHealth away from their care by the Massachusetts Behavioral Health Partnership, the Committee advocated for statutory protection for the individual's right of choice. As a result, language was included in line-item 4000-0500 of the FY'07 budget that protected that choice.

- The Committee worked with the Joint Committee on Elder Affairs to advance a new mental health initiative. The budget included funding for geriatric mental health services including residential care, case management, day treatment services, and to deinstitutionalize or divert elders with serious and persistent mental illness from institutionalized settings.

- The Committee worked with the Joint Committee on Education on another new initiative securing funding for early childhood mental health consultation services in early education and care programs.

Health Care Reform

- Working closely with the Joint Committee on Health Care Finance, the Committee ensured that the historic health care reform legislation protected all previously existing legal mandates for the provision of mental health and substance abuse services.

- The Committee was successful in including a section in the health care reform act that provided oversight authority to the Commissioner of the Department of Mental Health for all behavioral health services provided through MassHealth (Medicaid). Advocates stressed the need for this oversight authority to ensure that the quality of mental health services for clients who are covered by MassHealth is protected.

Increases to Funding of Mental Health Programs

Funding for Persons Aging into the Adult System (FY07 Budget) $6,000,000 (Increased by $3,000,000)
Line-Item: 5046-0000

This item will provide money for services for Department of Mental Health clients who are aging into the adult system from the child/adolescent mental health system or other systems of care if the clients meet the clinical eligibility criteria of the department.

This item was vetoed in part by the Governor with the explanation that the funding was being reduced to "the amount projected to be necessary."

The Legislature overrode the Governor's veto.

Homeless Mentally Ill (FY07 Budget) $2,750,000 (New Funding)
Line-Item: 5046-0000

This item will provide funding to expand programs that provide housing for the homeless mentally ill.

Jail Diversion Programs (FY07 Budget) $200,000 (Increased by $100,000)
Line-Item: 5046-0000

This item provides funding for jail diversion programs in the Commonwealth. In addition, this item mandates that of the $200,000, $100,000 will be marked for the jail diversion program in Framingham.

This item was vetoed in part by the Governor with the explanation that the funding was being reduced to "the amount projected to be necessary."

The Legislature overrode the Governor's veto.

Jail Diversion Programs in the Department of Mental Health (FY07 Budget) $300,000 (New Funding)
Line-Item: 5046-0000

This item provides funding for a pre-arrest jail diversion grant program at the Department of Mental Health. This money will be used to establish five new programs through the Department.

Fairwinds Clubhouse (FY07 Budget) $75,000 (New Funding)
Line-Item: 5046-0000

This item provides funding for the expansion of employment support services at the Fairwinds Clubhouse in Falmouth.

This item was vetoed by the Governor with the explanation that the funding was being reduced to “the amount projected to be necessary.”

The Legislature overrode the Governor’s veto.

Rental Subsidies (FY07 Budget) $3,000,000 (Increased by $500,000)
Line-Item: 7004-9033

This item provides funding for rental subsidies to clients of the department of mental health provided that the department establishes the amounts of those subsidies so that payment does not exceed the amount appropriated.

Juvenile Court Clinics (FY07 Budget) $500,000 (New Funding)
Line-Item: 5055-0000

This item provides funding for forensic services provided by the Department of Mental Health.

This item was vetoed by the Governor with the explanation that the “program expansion (is) not recommended.”

The Legislature overrode the Governor’s veto.

Early Childhood Mental Health Consultation (FY07 Budget) $1,400,000 (New Funding)
Line-Item: 3000-6075

This item provides funding for early childhood mental health consultation services in early education and care programs. Preference shall be given to services designed to limit the number of expulsions and suspensions. The department shall issue a report estimating the number of pre-school suspensions and expulsions that occur each year; the frequency of each type of mental illness or behavioral issues; and an analysis of the most effective intervention strategies.

Geriatric Mental Health Services (FY07 Budget) $350,000 (New Funding)
Line-Item: 9110-1640

This item provides funding for the Geriatric Mental Health Services program, including residential care, case management, day treatment services, and to deinstitutionalize or divert elders with serious and persistent mental illness from institutionalized settings.

Increases to Funding of Substance Abuse Programs

Step-Down Recovery Services (FY07 Budget) $5,000,000 (New Funding)
Line-Item: 4512-0201

This item provides funding for substance abuse step-down recovery services, otherwise known as level B beds and services, and other critical recovery services with severely reduced capacity. In addition a quarterly report to the house and senate committees on ways and means is required that addresses the number of individuals served by the step-down recovery services program.

Section 35 funding (FY07 Budget) $4,000,000 (New Funding)
Line-Item: 4512-0200

This item will provide for the establishment of 60 community-based beds in locked down non-correctional settings for men who have been civilly committed to a substance abuse treatment program pursuant to section 35 of chapter 123 of the General Laws (currently, civilly committed men are sent to Bridgewater where they receive treatment in a correctional setting sometimes along side violent criminals).

BMC Treatment Coordinators (FY07 Budget) $400,000 (Increased by $300,000)
Line-Item: 4512-0200

This item will provide funding for treatment coordinators for the drug court programs in the Boston municipal courts. Drug courts treat nonviolent, substance-abusing offenders by providing them with the option of treatment instead of incarceration.

District Court Treatment Coordinators (FY07 Budget) $200,000 (Increased by $100,000)
Line-Item: 4512-0200

This item will provide funding for treatment coordinators for the drug court programs in the district courts. Drug courts treat nonviolent, substance-abusing offenders by providing them with the option of treatment instead of incarceration.

New Beginnings (FY07 Budget) $250,000 (Increased by $100,000)
Line-Item: 4512-0200

This program helps identify the links between school discipline, delinquency, violence and achievement. It targets youth as early as middle school age and educates with current and accurate information regarding the effects and dangers of alcohol and drugs so they can make responsible decisions when confronted with alcohol and/or drugs.

Recovery Homes Rate Increase (FY06 Supp Budget) $8,000,000 (New Funding)
Section 98

Recovery homes, a crucial element in the continuum of care, are under-funded and have not received a rate increase for nearly a decade. This item would increase their daily rate by $20 (from $55 to $75 a day), which is much needed and brings them closer to breaking even.

This item was vetoed by the Governor with the explanation that the "funds either have not been requested by the Department of Public health or are presently being funded at the Department of Social Services".

The legislature overrode the veto.

Substance Abuse Counselors in Houses of Corrections (FY06 Supp Budget) $1,500,000 (New Funding)
Section 98

This item provides for substance abuse and mental health pilot programs in four houses of correction in Hampden County, Norfolk County, Middlesex County and Barnstable County. In each of the aforementioned houses of correction, one counselor shall be assigned for every two hundred inmates and each pilot program shall report upon the progress of the program and the rate of recidivism twice a year to the joint chairpersons of the mental health and substance abuse committee and to the chairpersons of the house and senate committee on ways and means.

Hampden County Residential Program for Women (FY06 Supp Budget) $150,000 (New Funding)
Section 98

This item would provide funding for and direct the Hampden County Sheriff to design and operate an innovative residential program for recently released female offenders in the Springfield area. This program will be a 12-16 bed, 24 hour program for women with gender specific wraparound services including, without limitation: finding and maintaining employment; finding additional education, finding stable, independent housing; substance abuse education; parenting skills; child reunification assistance; dealing with domestic violence and trauma. This will be a 3 year project.

Sobriety High Schools (FY06 Supp Budget) $2,250,000 (New Funding)
Section 98

This item would provide the one-time startup costs for three Sobriety High Schools in the following regions of the Commonwealth: greater Boston, greater Springfield and the north shore. Sobriety High Schools create safe and positive environments for youth that are recovering from substance abuse addiction. These high schools have been very successful in other areas of the country in curbing substance abuse among youth.

Pre-Arraignment Pilot Program (FY06 Supp Budget) $1,000,000 (New Funding)
Section 98

This is a pilot program in which the District Attorney of Essex County will be able to direct non-violent offenders into a non-correctional locked down substance abuse treatment facility in lieu of arraignment and a subsequent CORI record provided that the offenders agree to enter and treatment as well as pay restitution for any crimes committed in exchange for their arraignment being held in abeyance.

Youth Stabilization Program (FY06 Supp Budget) $1,500,000 (New Funding)
Section 98

The Bureau of Substance Abuse Services (BSAS) would procure for Youth Stabilization Services with the capacity to medically monitor for alcohol and drug use related withdrawal symptoms. This service would also have the clinical capacity to screen and assess for alcohol and drug use disorders and mental health concerns. Programming would be composed of two discrete services:

1) An acute care program with medical monitoring capacity that would triage to the next level of care under the direction of a medical doctor and nursing oversight. This would be composed of at least 15 bed unit for 13 to up to 18 year olds with the ability to address health and safety needs by gender.
2) A step down service that would stabilize youth and manage their cases to the next level of care based on individualized need. This transitional support service would provide stabilization and care coordination to residential or community based outpatient services- working with youth and their families and multi systems (BSAS Youth Services, Juvenile Court, and Department of Youth Services, Department of Social Services and/or probation).

CASA Start (FY06 Supp Budget) $750,000 (New Funding)
Section 98

CASA Start (Striving Together to Achieve Rewarding Tomorrows) is a community-based, school-centered program designed to keep high-risk preadolescents (8 to 13 years old) free of drug and crime involvement. The central notion underlying the program is that while rates of experimentation with drugs and alcohol are similar for preadolescents from all backgrounds, those who lack effective human and social support are at higher risk of continuing and intensifying substance abuse. Using an intensive and coordinated marriage of preventive services and community-based law enforcement, CASA Start addresses the individual needs of participants as well as the broader problems of their families and communities.

HEAT Program (FY06 Supp Budget) $400,000 (New Funding)
Section 98
It is the mission of the HEAT Program (Heroin Education Awareness Task Force) to educate the public, especially parents, about the extent of heroin use and abuse among young people in their community. The HEAT Program provides statistical and anecdotal

information to parents, school personnel and others on the problems within the community; offers tips to parents on how to identify drug use; and provides resource information for treatment. The appropriated funds will be expended to fund 10 beds through a Center for Addicted Behavior (CAB) program in conjunction with the HEAT program at the Woburn District Court.

Casa Esperanza (FY06 Supp Budget) $149,990 (New Funding)
Section 98

Increased funding for Casa Esperanza (CE) will allow CE to continue its development and implementation of "Familias Unidas," a national model in substance abuse recovery services, while expanding CE's capacity to provide critical recovery programming for children, increased integrated mental health services for families, and essential economic independence services to help men and women in recovery get the training and jobs they need to maintain their sobriety and sustain their families.

This item was vetoed by the Governor with the explanation that the "funds either have not been requested by the Department of Public health or are presently being funded at the Department of Social Services."

The legislature overrode the veto.

Saugus Drug Prevention (FY06 Supp Budget) $100,000 (New Funding)
Section 98

"provided further that $100,000 shall be expended for the prevention of substance abuse in the town of Saugus."

This item was vetoed by the Governor with the explanation that the "funds either have not been requested by the Department of Public health or are presently being funded at the Department of Social Services."

The legislature overrode the veto.

Budget Addendum

December 2006

On November 10, 2006, Governor Romney exercised his executive powers under Section 9C of Chapter 29 of the Massachusetts General Laws to cut $425 million from the FY '07 budget. A little over $400,000 was cut from substance abuse services and approximately $7 million was cut from mental health services. On December 1, 2006 as a response to public pressure, Governor Romney restored some of the 9C reductions. These included the restoration of funds to the Department of Mental Health for Adult Mental Health Services, Homelessness Services, and Adult Inpatient Facilities. The amounts bolded below were those restored on December 1.

At the time that this report went to print, the 9C Cuts impacted many of the accomplishments in the mental health and substance abuse budget cited in the earlier sections. The Committee Chairs have discussed these cuts with Governor-Elect Deval Patrick and it is their hope that these funds will be restored in January.

The following are the 9C reductions that effect mental health and substance abuse:

Agency/Program	Amount of Reduction
Department of Mental Health	
Administration	$454,289
Child/Adolescent	$844,668
Adult Mental Health Services	***$1,900,000***
Homelessness Services	***$260,098***
Emergency Services and Community	$369,812
Retained Revenue	$787,427
Forensic Mental Health	$500,000
Adult Inpatient Facilities	***$1,909,961***

The Department of Mental Health is also impacted by the $28 million cut of the Direct Care Worker Salary Reserve. This is in line item 1599-6901 and provides a needed increase for the salaries of direct care workers.

Agency/Program	Amount of Reduction
Department of Public Health	
Substance Abuse Step-Down recovery Services	$58,221
Gamblers' Treatment	$345,058
Department of Early Education and Care	
Early Childhood Mental Health Consultation	$16,302
Department of Elder Affairs	
Geriatric Mental Health Service Program	$4,075

Bills heard by the Joint Committee on Mental Health and Substance Abuse, 2005-2006

Forty-eight (48) bills were referred to the Joint Committee on Mental Health and Substance Abuse during the 2005-2006 legislative session. Thirty-two (32) bills were moved favorably by the Committee. Twenty-two (22) of these bills per Joint Rule 1E were sent by secondary referral to the Joint Committee on Health Care Financing. After review by Health Care Financing, eleven (11) bills moved forward with favorable reports from that committee. The following pages provide detailed information about these bills.

A review of the aforementioned bills indicates that the Committee focused on the prevention and treatment of mental illness and addictions, diversion of mentally ill and addicted individuals from the criminal justice system, mental health and substance abuse services within the criminal justice system, and generally expanding access to treatment.

While none of the individual bills that moved through the committee were enacted in the form presented, many of the concepts and goals involved were incorporated in the FY'06 Supplemental budget, the FY'07 budget, and the Health Care reform legislation as described in the previous section of this report. (See "Legislative Accomplishments", page 1)

Bill Summaries: Mental Health and Substance Abuse Committee Bills, 2005-2006

H1456, "An Act Relative to Homeless Shelters in the Commonwealth"

Sponsor: Representative Robert Fennell
Summary: This bill prohibits the consumption of alcohol or any narcotic on the grounds of shelters, lodging houses, and facilities housing the homeless. Each shelter and lodging house will work with the Department of Public Health to provide alcohol and drug abuse programs to its residents.
Action: Ought Not to Pass

H1608, "An Act Relative to Reimbursement for Drugs to Treat Mental Illness"

Sponsor: Representative Thomas Stanley
Summary: Allows Medicaid recipients to receive non-generic medications for the treatment of mental illness. The following types of medication will be made available: atypical antipsychotic medications; conventional antipsychotic medications; anti-depressant medications; anticonvulsant medications; and any other medication used in the treatment of mental illness.
Action: Favorable

H1609, "Resolve Providing for an Investigation and Study by a Special Commission Relative to the Decriminalization of Persons with Mental Illness"

Sponsor: Representative Ruth B. Balser
Summary: Establishes a commission to study and make recommendations regarding the diversion of people with mental illness from jails and prisons, mental health services available in jails and prisons, and services available to people with mental illness that are re-entering the community after being in jail or prison. The commission will include elected and appointed officials, a representative from the National Alliance for the Mentally Ill, mental health professionals, a former prisoner with mental illness, and a family member of a person with mental illness who was in jail or prison.
Action: Favorable (Oversight hearing held, see page 27)

H1610, "An Act to Require Equitable Payment from the Commonwealth"

Sponsor: Representative Angelo Scaccia
Summary: Makes EOHHS responsible for ensuring that network hospitals are compensated at their full negotiated rate for behavioral health services provided to MassHealth patients. The patients must also be clients of other agencies within the EOHHS, and it must be documented that there were no other appropriate placements for these clients.
Action: Favorable

H1611, "An Act Relative to the Civil Commitment Process for Persons with Mental Illness"

Sponsor: Representative Angelo Scaccia
Summary: Stipulates that civil commitment hearings for individuals who are in a mental health facility or Bridgewater State Hospital, or on antipsychotic medication, be held at the mental health facility unless the individual, the court, and the hospital request that it be held at an alternate site.
Action: Study

H1612, "An Act Relative to Services for Persons with Mental Illness Who are Living with Older Family Members or Primary Caretakers"

Sponsor: Representative Angelo Scaccia
Summary: This bill will require DMH to provide the option of residential and day services to DMH eligible individuals who have a family member or primary care taker who has either become medically ill or is under stresses that make the environment unsafe for either the caretaker or the individual with mental illness.
Action: Favorable with Changes

H1613, "An Act Relative to Mental Health Services"

Sponsor: Representative Jeffrey Perry
Summary: This bill would amend line item 8910-0003 to increase the number of regional behavioral and stabilization units to three by adding one in Barnstable County to serve the needs of incarcerated persons in Barnstable, Dukes, Nantucket, and Plymouth counties. These units provide forensic mental health services to individuals incarcerated in existing facilities.
Action: Favorable

H1614, "An Act Relative to the Civil Commitment of Women for Alcoholism or Substance Abuse at a Certain Facility"

Sponsor: Representative Kay Khan
Summary: This bill would prohibit the correctional facility in Framingham from being a placement option for females committed for alcohol and/or substance abuse. In order to meet the requirements of section 35, the Department of Public Health will be required to establish and maintain at least 15 secure treatment beds for women.
Action: Favorable

H1615, "An Act Creating Involuntary Outpatient Commitment Law for Mentally Ill Persons"

Sponsor: Representative Kay Khan
Summary: Establishes an involuntary outpatient commitment law, allowing the superintendent of a facility or hospital and a licensed physician or psychologist to petition the district court for the outpatient commitment of a patient. The patient must meet the following three criteria: the patient is mentally ill; the patient displays either a likelihood of causing serious harm, and/or incapacity to make decisions about treatment, and/or a grave disability; and the patient will

deteriorate without treatment. Petitions must include specific treatment plans that include the following: requirements for supervision; medication needs; assistance in obtaining employment, food, clothing, and shelter; the address of the patient's residence and the name of who is in charge there; the name and address of a person supervising the outpatient treatment plan; and the conditions for outpatient treatment. The first order for outpatient commitment will not exceed 90 days and subsequent orders will not exceed 365 days. This bill would allow any person to apply to the court stating his/her belief that a person currently being treated on an involuntary outpatient basis should no longer be treated.
Action: Study

H1616, "An Act Relative to Mental Health"
Sponsor: Representative Kay Khan
Summary: Requires that mental health services be provided to individuals in county and state correction facilities, as recommended by the American Psychiatric Association Task Force Report on Psychiatric Services in Jails and Prisons. These services will include, without limitation: suicide, mental health and substance abuse screening upon transfer; mental health assessment within two weeks of admission or transfer and periodically thereafter; a comprehensive mental health evaluation; suicide prevention; crisis intervention; an individualized plan of care; psychiatric services, including medication and medication monitoring; individual and group psychotherapy; evaluation for transfer to a mental health facility; and discharge planning, including referral to appropriate mental health services and sufficient medication.
Action: Favorable with Changes

H1617, "An Act to Review the Delivery of Behavioral Health Services in the Commonwealth"
Sponsor: Representative Douglas Petersen
Summary: Establishes a commission to review the Division of Medical Assistance's arrangements with managed care organizations. The commission will evaluate the following: the processes used to approve or deny services; the processes used to determine medical necessity; the coordination of policies that impact clients of DMH, DPH, and DSS; the coordination of policies with providers of services; whether providers are being compensated at rates appropriate for the provision of services; the terms and impact of the financial arrangements and incentives between DMA and managed care organizations and entities that manage behavioral health services.
Action: Favorable with Changes (Oversight hearing held, see page 27)

H2846, "Resolve Providing for an Investigation and Study by a Special Commission Relative to the Needs of Persons with Agoraphobia and Related Disorders"
Sponsor: Representative Anthony Petruccelli
Summary: Establishes a commission to review the state rehabilitation and human service plans to enhance services to persons suffering from agoraphobia, seizure

disorders, and traumatic syndromes. The commission will be made up of elected and appointed officials as well as members of advocacy groups.
Action: Study

H2854, "An Act Relative to the Health Care Needs of Adolescents in the Juvenile Justice Systems of the Commonwealth"

Sponsor: Representative Kay Khan
Summary: Authorizes the EOHHS and the EOPS to conduct a review of the health care and mental health care needs of adolescents in the juvenile justice system, adult correctional facilities, youth services system, and the social services system. This review will include a survey and determination of the needs of adolescent populations, the type of service, treatment program, and the spectrum of health and mental health care currently being received; the staff providing care; and other such information required to determine adequacy and scope of care. This bill requires the DYS to provide a full medical screening examination, laboratory testing, and other necessary physical or mental health examination to each child committed.
Action: Favorable, Committee Redraft, H4756

H2862,"An Act to Provide Services for the Medically Ill and Mentally Ill Persons"

Sponsor: Representative Angelo Scaccia
Summary: Creates 160 community residential placements with medical/nursing care components to serve people with mental illness. DMH will be responsible for devising a plan to develop these 160 placements. DMH will be given 5 years, beginning in fiscal year 2007, to implement this plan of creating 160 placements. Until these 160 placements are provided, this bill would require DMH to provide medical care to at least 12.5% of new DMH clients in community residential programs. These services will by funded by using money that had been intended for inpatient beds in DMH facilities, but that has not been used because of the closing of facilities. DMH will keep a separate list of persons waiting for community residential placements with medical/nursing care.
Action: Study

H2863, "An Act Relative to Providing Appropriate Medical Care for Persons in Mental Health Facilities"

Sponsor: Representative Angelo Scaccia
Summary: DMH will provide a comprehensive physical exam upon admission and annually thereafter. The comprehensive physical exam will be characterized by a determination of the level of nursing services the individual might need, or whether chronic disease or rehabilitation hospital services are required. DMH will create an individualized service plan for each individual identified with these specialized medical needs.
Action: Study

H2865, “An Act Providing for a Study by the Executive Offices of Health and Human Services Relative to Nonprofit Group Homes”

Sponsor: Representative James Fagan

Summary: Directs EOHHS to study a “fairness rule” to provide for a more equitable distribution of nonprofit group homes. The study will review the number and location of nonprofit group homes currently in use; analyze the ratio of nonprofit group homes in use to the population for each municipality; analyze the neighborhoods in which these nonprofit group homes are currently in use in terms of economic factors; and consider the feasibility of establishing a formula or guidelines to ensure an equitable distribution of group homes in municipalities based on population and economic composition of the neighborhood.

Action: Study

H2871, “An Act Concerning the Right of Persons Receiving Services from Programs or Facilities of the Department of Mental Health to Daily Access to Fresh Air and the Outdoors”

Sponsor: Representative Frank Smizik

Summary: This bill would add the right to daily access to fresh air and the outdoors to the list of fundamental rights.

Action: Favorable, Committee Redraft, H4757

H2872, “An Act Requiring the Department of Mental Health to Notify Crime Victims or their Families about the Release of Certain Criminals”

Sponsor: Representative Bruce Ayers

Summary: This bill would require the superintendent or commanding officer of any hospital, institution, or facility under the control of DMH to make notifications when a person confined or involuntarily committed to DMH is released. The victim, parents or guardian of a victim, or the witness to a crime or violent act will be notified in writing at least seven days in advance of release.

Action: Ought Not to Pass

H2942, “An Act Relative to Special Education Settlement Encourage and Fairness”

Sponsor: Representative Peter Larkin

Summary: Allows for a compromise to be made regarding the placement of a child in need of special education services. If either of the disputing parties request a compromise or settlement, then the hearing officer will review the compromise and order the parties to comply.

Action: Study

H3124, “An Act Relative to the Location of Methadone Clinics”

Sponsor: Representative Cheryl Coakley-Rivera

Summary: Requires methadone clinics to be more than 1000 feet from the real property lines of the following buildings: elementary schools; secondary schools; vocational schools; public schools; private schools; and licensed preschools or head start programs. Additionally, no methadone dispensing facility or clinic may

be located within 100 feet of a public park. Individuals operating these facilities or clinics have one year to comply.
Action: Study

H3125, "An Act Improving Access to Rehabilitation Counseling"
Sponsor: Representative Christine Canavan
Summary: Requires health insurers to reimburse rehabilitation counselors for outpatient mental health services by recognizing licensed rehabilitation counselors as licensed mental health professionals.
Action: Favorable

H3126, "An Act Relative to the Youth Diversion Program to Reduce Underage Drinking and Promote Healthy Choices"
Sponsor: Representative Peter Larkin
Summary: Creates a youth alcohol education program as an alternative to paying a fine for persons under the age of 21 found to have a detectable blood alcohol content of .02. Any person under 21, who has not had a prior criminal record, has not inflicted serious personal injury to or the death of another person may, in lieu of a fine and accompanied by a parent or guardian, enroll in a youth education program established and administered by DPH. This program will be designed for the education, assessment and treatment of youth at risk of alcohol and controlled substance abuse. Satisfactory completion of the program requirements shall be in lieu of any conviction, adjudication or motor vehicle penalty.
Action: Favorable, Committee Redraft, H4980

H3127, "An Act Increasing Public Safety by Ensuring Access to Substance Abuse Treatment"
Sponsor: Representative Byron Rushing
Summary: This bill will require DPH to establish a program of assistance for the treatment of all substance dependent persons who are not eligible for assistance under any other program and either lack private health insurance coverage or have health insurance that does not cover all necessary treatment. The income eligibility standards will not be less than 200% of the non-farm income poverty guidelines. DPH will assist all those eligible for treatment in enrolling in the programs, and the Director will publicize these regulations.
Action: Favorable with Changes

H3556, "An Act to Amend The Commonwealth's Drug Treatment Program, to Allow for the Diversion of Low-level Offenders Under Court Supervision"
Sponsor: Representative Martin Walsh
Summary: Offers drug treatment diversion for low-level drug offenders (not involved with the sale of drugs). This bill would extend the availability of the program from only first time offenders to include second time offenders. With this bill, a drug dependent person's past records, and history of complying with terms of admission, will no longer be considered by the Director of the facility in determining whether to admit the person to a facility. This bill stipulates that a

positive drug-screening urinalysis alone will not be considered a violation of the probation.
Action: Favorable with Changes

H3945, "An Act Relative to the Establishment of an Alcohol Commission"
Sponsor: Representative Elizabeth Malia
Summary: Establishes a commission to investigate and study the impact of alcohol abuse and its consequences. The topics to be addressed include, without limitation: current statutes, regulations, and policies; availability and access to treatment services; costs of lost productivity in employment, traffic fatalities, injuries, and law enforcement efforts; and how to address alcohol abuse by minors. The commission will be made up of elected and appointed officials as well as members of advocacy groups.
Action: Favorable with Changes (Sub-committee on Alcoholism established, see page 55)

H4572, "An Act Requiring Notice of the Treatment of Minors for Drug Overdoses"
Sponsor: Representative Brian Wallace
Summary: Requires that parents or guardians shall be notified when a minor is treated for a drug overdose.
Action: Favorable with Changes; became H5032

H4772, "An Act Establishing Teen Mental Health Drop-In Centers"
Sponsor: Representative Jennifer Flanagan
Summary: Establishes 10 pilot teen mental health drop-in centers that would provide free and confidential access to mental health professionals. Centers will also provide referrals for additional care as needed. A screening board including one mental health professional, a community member, and a majority of members under age 20 (nominated by Teens Leading The Way) shall select which communities receive facilities based on the criteria.
Action: Favorable

S76, "A Resolve Providing for an Investigation and Study by a Special Commission Relative to the Needs of Persons with Agoraphobia and Related Disorders"
Sponsor: Senator Susan Fargo
Summary: Establishes a commission to study if persons suffering from agoraphobia seizure disorders, traumatic syndrome, and related disorders which result in a home-bound state have been under-served in the Commonwealth. The bill will assemble a commission of legislators, agency representatives, and service providers who work with this population.
Action: Study

S126, "An Act to Ensure Parents of Children Prescribed Psychotropic Drugs Receive Adequate Information"

Sponsor: Senator Charles Shannon
Summary: This bill asks the Commissioner of DMH to convene a task force which will develop a list of the 20 most commonly prescribed psychotropic medications for children which includes a description of the most common side effects of each medication.
Action: Study

S127, "An Act Protecting Juveniles and Parental Rights in Juvenile Alcohol and Drug Rehabilitation"

Sponsor: Senator Charles Shannon
Summary: Expands the definition of "alcoholic" and "substance abuser" to include use which substantially interferes with "academic functioning" or with "the social or economic functioning of his family" for the purpose of civil commitment for juveniles. Juveniles can be committed by "any parent, guardian, police officer, physician, probation officer or department of social services representative."
Action: Study

S1139, "Resolve Relative to Establishing a Commission to Set Guidelines for Development Costs for Housing Disabled Adults"

Sponsor: Senator Scott Brown
Summary: Establishes a commission to look at the need for state-subsidized housing for mentally disabled adults. The commission would develop fair guidelines for evaluating the cost for state-subsidized development of such housing. The commission would also develop an index for the average cost of housing in each city and town. The commission will include both elected and appointed officials, one human services provider, and one legal guardian of a resident of housing for those with mental disabilities.
Action: Favorable

S1140, "An Act to Control the Use of Methamphetamine"

Sponsor: Senator Harriette Chandler
Summary: Regulates the sale of pseudophedrine which is found in many cold medications but can be used to make methamphetamine. This bill requires pharmacists to be sole dispensers, sellers or distributors of pseudopehdrine. Individuals buying pseudophedrine would be required to show photo identification. Individuals would be allowed to purchase up to 9 grams for any thirty-day period. Exempt from these restrictions are compounds, mixtures or preparations which are in liquid, liquid capsule, or gel capsule form where pseudophedrine is not the only active ingredient.
Action: Favorable Committee Redraft, S2183

S1141, "An Act to Ensure Adequate Adult Day Health Services"

Sponsor: Senator Harriette Chandler

Summary: Establishes three MassHealth reimbursement rates for providers of adult day health services. One rate is for a basic level of care. The second rate is for "Complex" care. The third is for dementia-specific care. Dementia-specific adult day health programs would be reimbursed at least at the "Complex" care rate. The Executive Office of Health and Human Services will review and either approve or disapprove of the rates.

Action: Favorable

S1142, "An Act Requiring Victims to be Notified of Certain Hearings Concerning the Custodial Status of Individuals Adjudged Not Guilty of a Crime by Reason of Mental Illness or after Being Found Not Competent to Stand Trial"

Sponsor: Senator Cynthia Stone Creem

Summary: Changes the person to be notified, when an individual found not guilty by reason of mental illness or found not competent to stand trial and is housed in a mental health facility or Bridgewater State Hospital applies for a discharge, from 'the names of all persons" interested to "the names of the District Attorney for the District in which the person was adjudicated." Also adds the District Attorney to the list of those to be notified when a hearing is scheduled for the individual. This bill additionally adds the victim and victim's family members to those to be notified of a hearing. It also requires notification of victims by an individual's commitment facility when the individual receives temporary, provisional or final release from a facility, when the individual is moved to a lower security facility, or should the individual escape from the commitment facility.

Action: Study

S1143, "An Act Relative to Preventing the Use of Ecstasy and the Abuse of Pharmaceutical Drugs"

Sponsor: Senator Cynthia Stone Creem

Summary: Requires the EOHHS to develop a public service campaign aimed at educating young adults and teenagers on the dangers of using or abusing the following drugs: ecstasy, oxycontin, hydrocodone, vicodin, and any other drugs the EOHHS believes should be included. The campaign will emphasize the physical and mental health risks of abusing the aforementioned medications. The campaign must involve district attorneys, police, university and high school officials, businesses, students, parents, teachers, and community organizations.

Action: Favorable

S1144, "An Act Establishing the Public Guardianship Commission"

Sponsor: Senator Cynthia Stone Creem

Summary: Establishes the public guardianship commission which would serve as a potential guardian; contract with agencies to be guardians either for those who are unable to pay or for individuals for whom no other guardian is available or willing to accept the role. The commission would set priorities for who would be eligible for services, what services would be provided, who will provide the

services and the how the services would be delivered. The commission would be made up of nine unpaid members, all appointed by the SJC, including: one appointed by the chief judge of the probate and family court; one person with a disabilty; one member over sixty years old; one advocate for persons with disabilities; one advocate for elderly persons; and one member who represents elder services or other human service providers. Separate from the individual's guardian, an independent counsel would need to be available for each individual for court proceedings or to petition for discharge of the guardian. An independent clinical review would be made annually to determine if the individual still needs a guardian. If the person is a minor, a guardian will only be appointed after the court determines that responsibility for the minor cannot be accepted by DSS. The commission would be required to maintain records of each case which include financial and personal information necessary for the commission or fiduciary agency to carry out its responsibilities.
Action: Favorable

S1145, "An Act Regulating the Citing of Methadone Treatment Facilities"
Sponsor: Senator Jack Hart
Summary: This bill would require any methadone facility to receive approval from the local town or city council before it is allowed to operate within that city.
Action: Study

S1146, "An Act Requiring the Division of Medical Assistance to Reimburse Hospitals for the Costs of Psychiatric Patients on Medical Units"
Sponsor: Senator Richard Moore
Summary: Adds language to ensure that hospitals are reimbursed at DMA's "standardized payment amount per discharge rate" for services provided to mentally ill patients who are hospitalized on medical units.
Action: Favorable

S1147, "An Act to Preserve Access to Behavioral Health Services"
Sponsor: Senator Richard Moore
Summary: Ensures hospitals receiving MassHealth can only admit patients based on clinical need. The bill also establishes a commission to study acute and sub-acute psychiatric services in the Commonwealth including: access to care; the supply of inpatient beds; coordination of care between state agencies and health care providers; and a comparison of the differences between outpatient and inpatient costs and the amount of reimbursement provided by EOHHS. The bill establishes an additional advisory committee to study ways to reduce costs.
Action: Study

S1148, "An Act to Provide Equitable Coverage for Substance Abuse"
Sponsor: Senator Richard Moore
Summary: Guarantees that all insurance policies that reimburse or pay a provider of health care services do not discriminate against individuals seeking treatment for substance abuse. Treatment and diagnosis of these illnesses would be

guaranteed using the same terms and conditions as benefits offered for physical illnesses. Co-payments, deductibles, or service limitations may not be imposed on the diagnosis or treatment of substance abuse which are higher than co-payments, deductibles or service limitations imposed for physical illnesses.
Action: Favorable

S1149, "An Act Authorizing Educational Psychologists to Receive Certain Insurance Payments"
Sponsor: Senator Richard Moore
Summary: This bill would amend the definition of "licensed mental health professional" to include educational psychologists on the list of mental health practitioners who can be reimbursed by insurance companies.
Action: Favorable

S1150, "An Act Making Technical Corrections to Chapter 232 of the Acts of 1998"
Sponsor: Senator Michael Morrissey
Summary: Changes name of drug Ketamine Hydrochloride so that it is called Ketamine (established conformity with Federal law).
Action: Favorable

S1151, "An Act to Impose a Civil Fine for the Possession of Marijuana"
Sponsor: Senator Charles Shannon
Summary: Changes the penalties for possessing small amounts of marijuana so that those found to possess less than an ounce would be subject not to imprisonment but to a civil fine of $250. Those possessing an ounce or more of marijuana would still be subject to imprisonment. The bill changes the record for first time offenders so that their record shows only a civil infraction. Also, possession of marijuana will not be considered as a conviction and cannot be used as a basis for denial or revocation of a driver's license.
Action: Favorable

S1153, "An Act to Establish a Jail Diversion Program in the Department of Mental Health"
Sponsor: Senator Karen Spilka
Summary: Establishes a new "pre-arrest" jail diversion program based on the model of the Framingham Jail Diversion Program. The program would divert primarily non-violent offenders to community-based mental health or substance abuse services. Requires psychiatric personnel be located at the police departments and that dispatchers and first-responders be trained to identify persons with mental illness.
Action: Favorable

S1155, "An Act to Ensure Adequate Adult Day Health Services"
Sponsor: Senator Marian Walsh
Summary: Establishes three MassHealth reimbursement rates for providers of adult day health services. One rate is for a basic level of care. The second rate is

for "Complex" care. The third is for dementia-specific care. Dementia-specific adult day health programs would be reimbursed at least at the "Complex" care rate. The Executive Office of Health and Human Services will review and either approve or disapprove of the rates.
Action: Favorable

S1156, "An Act Relative to Substance Addiction Treatment"
Sponsor: Senator Marian Walsh
Summary: Raises money to pay for substance abuse treatment by increasing the excise taxes on manufacturers, sellers and importers of alcoholic beverages. Creates a special fund called the Substance Abuse Health Protection Fund modeled on the Tobacco Settlement Fund. The money from this fund will be spent to provide or supplement funding for four purposes: comprehensive substance abuse treatment for individuals who are dependent on or addicted to alcohol and/or controlled substances and who have no private or public health insurance that would cover the treatment; to fund substance abuse treatment programs under the Office of Community Corrections, the Department of Corrections, the Department of Social Services, the Department of Youth Services and the Office of the Commissioner of Probation; for comprehensive school health education programs which would incorporate information related to the hazards of alcohol and controlled substances use; for workplace and community substance abuse prevention and drinking cessation programs, substance abuse-related public service advertising, and for drug and alcohol education programs.
Action: Favorable Committee Redraft, became S2268

S1157, "An Act Relative to Reckless Endangerment"
Sponsor: Senator Marian Walsh
Summary: Add reckless endangerment of a "disabled person" to the crimes punishable by this law. "Disabled Person" is defined as one who is "mentally retarded" or otherwise "mentally or physically disabled and as a result of such mental or physical disability is wholly or partially dependent on another person or persons to meet his daily living needs."
Action: Favorable

S2109, "An Act Relative to the Department of Mental Health Inpatient Study Commission"
Sponsor: Senator Harriette Chandler
Summary: Establishes a commission to study the feasibility of constructing a new inpatient (DMH) facility in central MA for clients of DMH and others. Study shall look at the design, costs, financing, timeline for development, administration, and sitting of the facility.
Action: Favorable with Changes

Informational Hearings

Recognizing that the Joint Committee on Mental Health and Substance Abuse was new, the Chairs began the session by scheduling two informational hearings in order to educate the Committee members and members of the public about what was to become the scope of the Committee's work. One was focused on mental health and the other on substance abuse.

Substance Abuse Informational Hearing – May 2, 2005

The substance abuse hearing focused on the extent of the problem of addictions in Massachusetts and proposals to address the need for services. Testimony at the substance abuse hearing was presented by the members of the Administration, Representative Steven Walsh on behalf of the Oxycontin Commission, district attorneys and judges, substance abuse treatment providers, members of the medical community and pharmaceutical manufacturers.

Department of Public Health Commissioner Paul Cote and Assistant Commissioner Michael Botticelli, Director of the Bureau of Substance Abuse Services, described the extent of the problem in Massachusetts and the proposed steps that would be taken to combat the rising tide of addiction, with particular emphasis on alcohol and the growing problem of heroin and Oxycontin.

On May 16, 2005, Lieutenant Governor Kerry Healey provided a follow up briefing to the Joint Committee during which she shared with the committee members the State's Substance Abuse Strategic Plan) in advance of its subsequent formal release. The 93 page strategic plan focuses on prevention and established the Governor's Interagency Council on Substance Abuse and Prevention, on which both Committee Chairs serve.

The Strategic Plan is a comprehensive approach to the substance abuse problems in the Commonwealth, specifically highlighting prevention as a critical component. The Interagency Council oversees implementation of the initiatives the Strategic Plan and develops, recommends, and supports other initiatives and programs that effectively direct existing resources.

In addition, the Strategic Plan focuses on identifying, treating and preventing drug use in schools, implementation of an overdose tracking system in state hospitals, expanded detox and other treatment programs, a statewide education campaign on OxyContin and other opioids, and expanded treatment for incarcerated individuals.

District Attorneys Jonathan Blodgett of Essex County, Martha Coakley of Middlesex County, and William Keating of Norfolk County testified to the extent of the problem. They recommended a strategy that would include law enforcement, education, and treatment.

Justices Peter Anderson and Rosemary Minehan described the success of drug courts and also urged an expansion of services so that anyone willing to seek treatment would be able to access it.

Lieutenant William Ostiguy brought to the Committee's attention the concept of "Sobriety High Schools." These are programs where adolescents coming out of substance abuse treatment can attend high school in a sober environment. He recommended that we establish them here in Massachusetts.

Representatives from the drug companies that produce Oxycontin and Suboxone also testified.

Addiction treatment providers and advocates provided valuable testimony and urged that Massachusetts restore the programs that had been cut during the fiscal crisis.

Mental Health Informational Hearing – May 9, 2005

The mental health hearing provided members of the Committee with information about current issues related to the provision of mental health services for children and adults, as well as information related to two particular problems facing the mentally ill – homelessness and involvement with the criminal justice system.

Secretary Ronald Preston, Executive Office of Health and Human Services, and Department of Mental Health (DMH) Commissioner Elizabeth Childs testified. They described the advances in treatment available to the mentally ill and discussed the involvement of mental health issues in other agencies.

Commissioner Childs stressed the goals of DMH:

1. Simplified and accessible services
2. Flexible, individualized services in the least restrictive setting
3. Focus on recovery and rehabilitation
4. A holistic approach in care and treatment, with attention to mental and physical health, housing, employment, relationships, school and family
5. Emphasis on early intervention and prevention
6. Peer support and family involvement

Department of Corrections (DOC) Commissioner Kathleen Dennehy testified that there is a prevalence of mental illness in the DOC as 24% of the total DOC population are "open mental health cases." Breaking that statistic out by gender, the Commissioner added that 21% of the male population and 66% of the female population are "open mental health cases." 1,535 inmates are on mental health medications representing 15% of the total DOC population. Women have a higher incidence of being on medication than men. Fully 28% of all DOC pharmacy costs are for atypical medications used to treat mental illness. Commissioner Dennehy described special treatment units within the DOC.

Annually, 2,500 individuals participate in the Correction Recovery Academy, a program that lasts nine months. The Academy operates as a designated residential treatment unit and addresses substance abuse as well as issues such as anger management and violence reduction.

Judge Rosemary Minehan provided testimony about the role of the courts in the mental health system. The court clinic system is the gateway from courts to DMH. Under this system, a forensic psychologist will visit the courthouse, evaluate the client, and provide testimony during the hearing. Often, the client is then committed to a private psychiatric hospital. In civil commitment hearings, if the psychiatric hospital determines that the client is mentally ill then the hospital will file a petition to commit that person. The judge also testified that more secure beds were needed for women committed under MGL Chapter 123 Section 35 for substance abuse treatment.

The Massachusetts Behavioral Health Partnership (MBHP) and the Massachusetts Association of Health Plans described the mental health services that are provided to MassHealth members.

Representatives Kay Khan and Doug Petersen, co-chairs of the Mental Health Caucus testified about the advocacy done within the legislature by the Caucus.

Massachusetts Association of Behavioral Health Systems, Inc. (MABHS), which represents 44 inpatient behavioral health cites in Massachusetts, provided testimony about problems with reimbursement, the needs of "stuck kids" (patients being held in units while the State searches for a discharge placement), and cuts to the detox system.

The Massachusetts Mental Health Coalition, representing providers, consumers, and community based clinics, discussed their concerns about the impact of managed care on mental health practice noting the increase of administrative burdens, the loss of clinical control, and the lack of uniformity from the various health plans.

Additional issues of concern raised by the Massachusetts Psychiatric Society were the need for more comprehensive mental health parity legislation in the state and homelessness of the mentally ill.

Three organizations representing consumers - NAMI, Parent-Professional Advocacy League, and M-Power - provided testimony on a number of issues of importance to their constituencies. Of particular concern were the lack of community based placements for individuals coming out of state hospitals, difficulty accessing providers who work with children, access to medications, and a general concern for funding for services in the community to support people with mental illness and their families.

Many groups and individuals – including the American Academy of Pediatrics – MA Chapter, The Children's Mental Health Task Force of the AAP, the Children's Mental Health Task Force of the Boston Bar Association, representatives from the Psychiatry Department at Children's Hospital, and Marylou Sudders, CEO of the Massachusetts

Society for Prevention of Cruelty to Children – focused their testimony on the unique needs of children. There was discussion of the need for early intervention through schools and pediatricians' offices. There was considerable focus on barriers to treatment for children and all called for increasing access. The dearth of child psychiatrists was noted as a significant problem. Also, the involvement of youngsters in the criminal justice and the need for CHINS reform was noted.

Advocates for mental health including the Massachusetts Association of Mental Health and Mental Health and Substance Abuse Corporations of Massachusetts (MHSACM) testified that there is a need to create a unified, state-supported mental health system.

Lyndia Downie, President and CEO of Pine Street Inn, testified that supportive housing keeps mentally ill people from becoming homeless. She cited the loss of rental subsidies and its impact on homelessness.

Legal groups that work with people with mental illness raised the issue of the involvement of the mentally ill in the criminal justice system when they don't receive the proper services, i.e., youngsters stuck in psychiatric beds when appropriate residential placements are not available and the barriers to service as a result of managed care. The Mental Health Legal Advisors Committee and the Mental Health Litigation Unit of the Committee for Public Counsel Services and the Disability Law Center testified concerning legal rights of the mentally ill.

Representatives from the Framingham Jail Diversion program described their program as a joint effort between the Framingham Police Department and Advocates Inc., a mental health agency. The program allows social workers to train police officers on how to work with people with mental illness and allows police officers to train social workers on how to work effectively in the criminal justice system. In its first year the jail diversion program was involved in a total of 469 interventions of which 212 were actual "jail diversion events." Of the 212 cases, 103 were referred to outpatient behavioral healthcare and 55 were transported to the emergency room.

Leslie Walker of Massachusetts Correctional Legal Services explained that in prison "the weak and the different are often preyed upon." She charged that mentally ill prisoners are often isolated, tortured, taunted, or even encouraged to commit suicide. Of the approximately 10,000 prisoners in custody of the Department of Corrections, 1,500 to 2,000 have mental illness, she noted.

The Massachusetts Law Reform Institute testified with concerns about the effect of the Governor's welfare proposal on the mentally ill.

Oversight Hearings

<u>MassHealth Behavioral Health</u>
Hearing Date: January 17, 2006

<u>Background:</u>

Mental health advocates contacted the Committee on Mental Health and Substance Abuse to inform them that MassHealth, the state's Medicaid plan, was shifting individuals' coverage from the Primary Care Clinician (PCC) Plan to one of the four managed care organizations (MCOs). Mental health advocates were concerned about these conversions as it might impact those individual with mental illness. The behavioral health services for the PCC plan are managed by the Massachusetts Behavioral Health Partnership (MBHP) the state's behavioral health carve-out. Many advocates, providers, and consumers believe that MBHP does a good job and worried that these individuals' mental health care would suffer if they lost the care they receive from MBHP.

Recognizing that the legislature was integral in passing the enabling legislation in 1996 that established MassHealth, and with the establishment of the Mental Health and Substance Abuse Committee this term, the Committee chose to schedule an oversight hearing to review the structure and delivery of MassHealth mental health and substance abuse services generally. In addition, this hearing provided a venue for responding to the specific concerns that had been raised regarding the conversions within MassHealth.

<u>Overview of Hearing:</u>

On January 17, the Joint Committee on Mental Health and Substance Abuse co-chaired by Representative Ruth Balser and Senator Steven Tolman held an oversight hearing on MassHealth Behavioral Health.

The Secretary of Health and Human Services, Timothy Murphy, appeared before the Committee as the lead witness to answer questions about the current structure and delivery of services to MassHealth clients. He was joined by Department of Mental Health Commissioner Elizabeth Childs, Department of Public Health Commissioner Paul Cote and Medicaid Director Beth Waldman.

Committee members questioned the officials about various concerns. These included the amount of time it takes agencies to conduct the RFR process and get new programs up and running, the significant "unmet need" of those seeking treatment for addictions and the oversight role of the Commissioner of the Department of Mental Health with respect to all behavioral health services under MassHealth.

The Committee also heard from MBHP, the four MassHealth-contracted managed care organizations, three distinguished academics, and various advocacy organizations. Additionally, numerous consumers shared their remarkable personal stories with lawmakers. Many told of particular programs or services within the public behavioral

healthcare system that have helped them through the challenges and triumphs of their recovery.

Outcome:
As a result of the hearing and additional meetings, the Committee supported two pieces of legislation that were ultimately enacted, that would protect the quality of behavioral health services for MassHealth recipients.

Recognizing that the Department of Mental Health is the most qualified agency for overseeing the delivery of behavioral health services, the Committee's work resulted in inclusion of Section 113 of the Health Care Reform Bill that ensures the oversight of the DMH in contracting for services for MassHealth. In addition, the section required that the EOHHS inform the Joint Committees on Mental Health and Substance Abuse and Health Care Finance of any changes to the system of care. While this language was vetoed by the Governor, the legislature was successful in overriding that veto. The language of Section 113 of the Health Care Reform Bill:

> *SECTION 113. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall not make any change to the financing, operation or regulation of, or contracts pertaining to, the provision of behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI SCHIP, and any MassHealth expansion population served under Section 1115 waivers, nor shall it recommend or procure, by request for response or otherwise, any such changes, nor shall it seek approval from the federal Centers for Medicare and Medicaid Services for any such changes, until it has submitted a report outlining the proposed changes, together with its reasons and an explanation of the benefits of such changes, to the joint committees on mental health and substance abuse and health care financing; and further, all managed care organizations contracting or delivering behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI SCHIP, and any MassHealth expansion population served under Section 1115 waivers, and youth in the care and custody of the department of social services or the department of youth services, including any specialty behavioral health managed care organization contracted to administer said behavioral health services, shall obtain the approval of the commissioner of mental health for all of the behavioral health benefits, including but not limited to policies, protocols, standards, contract specifications, utilization review and utilization management criteria and outcome measurements. For purposes of this section, "specialty behavioral health managed care organization" shall mean a managed care organization whose primary line of business is the management of mental health and substance abuse services.*

Additionally, the Committee recognized that protecting the right of MassHealth recipients to choose their health plan was essential. Legislation was enacted that protects that freedom of choice in the Fiscal Year '07 budget in line-item 4000-0300:

> *Notwithstanding the provisions of any general or special law to the contrary, the secretary of the executive office of health and human services shall not reassign to a managed care plan under contract with the Office of MassHealth the behavioral health benefit of any eligible person when such benefit is managed by MassHealth's specialty behavioral health managed care contactor, after the benefit is elected by or initially assigned to such person, unless such person provides written or verbal consent to the reassignment.*

Children's Mental Health
Hearing Date: March 6, 2006

Overview of Hearing:
On March 6, 2006, the Joint Committee on Mental Health and Substance Abuse chaired by Senator Steven Tolman and Representative Ruth Balser held an oversight hearing on Children's Mental Health.

The hearing provided a venue for the public discussion of the Final Report of the Mental Health Commission for Children (the Commission), which was released July 1, 2005. The Commission was created in 2002 pursuant to Chapter 177 of the Acts of 2001 and its primary focus was the collection of data to better understand the issues pertaining to the availability of or gaps in mental health services for children and youth. Ultimately, the Commission developed recommendations for improving the mental health system for children in the Commonwealth.

The Commissioner of the Department of Mental Health (DMH), Dr. Elizabeth Childs and Assistant Commissioner Joan Mikula appeared as the lead witnesses and answered questions regarding DMH programs as well as what principles the DMH believes should guide treatment. The Committee also heard from various task forces, commissions and legal and advocacy groups. These groups were questioned on what could be done to improve mental health care and what roles community organizations should serve in providing these services.

There was a great deal of consensus on what needed to be done. The individuals and groups that presented largely agreed that treatment should be guided by the following principles: support for appropriate care; mental health parity; family involvement and support; and prevention. In addition, all of the presenters agreed that schools needed to play a more significant role.

Conclusion:
The testimony pointed to gaps in services for children. Of particular note was the lack of services in schools and pediatricians' offices. More evaluation and screening needs to be done in these settings. Additionally, there is a great need for more community services specifically focused on the needs of children with mental health issues.

The Committee supported the recommendations of the Final Report of the Mental Health Commission for Children. These recommendations include: maintaining a continuum of care so that children will be treated at the appropriate level and only for as long as is therapeutically necessary; supporting true mental health parity; and, ensuring early identification of mental health problems. Additionally, they recommend supporting the centrality of the Department of Mental Health so that there is an agency that takes the lead for care planning and coordination for all children and adolescents served with mental health needs.

The Committee recommends monitoring progress towards these goals with DMH.

Mental Health and Substance Abuse in Prison and Jails

Hearing Date: March 20, 2006

Overview of Hearing:

On March 20, 2006, the Joint Committee on Mental Health and Substance Abuse co-chaired by Representative Ruth Balser and Senator Steven Tolman held an oversight hearing on mental health and substance abuse services in prisons and jails. While the Committee has already made mental health and substance abuse services in prisons and jails one of the focuses of its work this session, this hearing took on extra significance following a number of suicide attempts and one completed suicide of a prisoner in custody.

Commissioner Kathleen Dennehy, from the Department of Corrections (DOC) testified in regard to the current procedures for handling mentally ill inmates. Dr. David Powers shared recommendations based on his review of Department of Corrections' institutions as part of the Harshbarger Commission. Additionally, testimony was provided by Department of Mental Health Commissioner Dr. Elizabeth Childs; UMass Medical School, which has the contract for behavioral health services with DOC; Sheriffs from Hampden and Middlesex; President of the MA Sheriffs' Association; Spectrum Health Services; and, several advocacy groups.

Many of those who testified argued that prisons and jails in Massachusetts have become *de facto* mental hospitals. According to DOC statistics, 21% of all male and over 60% of all female inmates are "open mental health cases." Adding in substance abuse problems to the mental health problems results in a statistic of more than 80% of the prison population suffers from these illnesses. It was asserted that prisoners with mental illness are likely to be preyed upon by fellow inmates or punished for suicidal gestures or behavioral abnormalities and subsequently placed into segregated units. This practice, along with a lack of proper training and sensitivity from correction officers and insufficient mental health resources, contributed to the suicides of several inmates, according to powerful testimony offered by family members of mentally ill inmates.

Conclusion:

Recognizing the prevalence of mental illness and addictions in the prison population, the Committee agreed to continue its focus on these issues. There was general agreement that there is a strong need to follow-up on the recommendations of the Harshbarger Commission and that the Department of Corrections should be monitored for its implementation of these recommendations which include enhancing mental health care through improved staffing and training and increased residential treatment capacity.

Mental Health Parity

Hearing Date: April 3, 2006

Overview of Hearing:

On April 3, 2006, the Joint Committee on Mental Health and Substance Abuse co-chaired by Senator Steven Tolman and Representative Ruth Balser held an oversight hearing on mental health parity. Dr. Elizabeth Childs, Commissioner of the Department of Mental Health gave an overview on the current Massachusetts parity law. She was joined by agency heads from the Department of Mental Health, Office of Patient Protection, Bureau of Managed Care, researchers, provider groups, and a number of advocacy groups including the National Alliance for the Mentally Ill, Massachusetts Chapter. The hearing assessed the impact of Chapter 80 of the Acts of 2000, "An Act Relative to Mental Health Benefits" commonly referred to as the "Parity Law." The hearing examined the impact of the law and whether further legislative action was needed.

While the Parity Law significantly increased coverage for mental health for people in Massachusetts, it was not a "comprehensive" parity bill that would cover all psychiatric conditions to the same extent as all other medical conditions. Rather, there are limits to coverage, especially of those conditions deemed "non-biological." Many mental health providers and consumers felt that with five years having passed, it would be a good time to review the impact of the Acts of 2000 and consider possible improvements.

Conclusion:

It is the view of all those who testified that Chapter 80 of the Acts of 2000 or the "Parity Law" must be expanded. The Committee is also cognizant that due to the exemptions imposed by the Employee Retirement Income Security Act of 1974 (ERISA) on state law, there is a need for Federal legislation in this area and commends Massachusetts Senator Edward Kennedy for his leadership on that issue.

Oversight Hearings: Testimony Summaries

MassHealth Behavioral Health

Executive Office of Health and Human Services

Timothy Murphy, Secretary of the Executive Office of Health and Human Services (EOHHS), testified that the Agency aims to improve the cost efficiency of MassHealth as well as to improve access to and quality of services. Secretary Murphy asserted that he believes that Massachusetts has benefited from the current model but he indicated that the state can do better by analyzing outcomes, taking advantage of health care information technology, identifying differences in all the models, and signing contracts that allow coordinated care. He pointed out that with the upcoming review of contracts through the re-procurement process it is incumbent upon EOHHS to analyze how every dollar is spent.

When Secretary Murphy was asked about the rumors that the Administration has plans to eliminate the Primary Care Clinician Plan's behavioral health carve-out, he stated that the Administration has no plan to radically restructure the behavioral healthcare delivery system but is looking to ensure that tax dollars are well spent. Secretary Murphy noted that it was imperative for the state to continue to take in and review the data about MassHealth to evaluate quality, access and cost efficiency of the program.

The Secretary also noted that one of the biggest challenges facing the Agency is the tremendous growth in the rate of health care needs and costs. A number of the Committee members asked questions regarding the services provided by the Bureau of Substance Abuse (BSAS) within the Department of Public Health. The Committee members wanted to know the number of individuals using BSAS services that are privately insured, have Medicare, have MassHealth, or do not have coverage. Commissioner Cote stated that he would have to get back to the Committee with this information.

Massachusetts Behavioral Health Partnership

The Massachusetts Behavioral Health Partnership (MBHP) is a product of Value Options and has been the state's behavioral health contractor since 1996 and has worked closely with the Commonwealth for 10 years to build a nationally recognized public behavioral health system. At the hearing MBHP was represented by Nancy Lane, Chief Operating Officer of Value Options; John Straus, VP of Medical Affairs; and Scott Taberner, CEO of MBHP.

In their testimony, MBHP noted that they have over 1,200 behavioral health providers and work closely with more than 380 primary care clinicians. The carve-out has a performance based contract with high accountability to the Commonwealth which allows Massachusetts to track and use information affecting behavioral health programming.

Twice a year MBHP reports on care management programs. The most recent reports show that physical health care costs were down 24% and behavioral health costs were down 61%. MBHP reports that its effectiveness is due to the fact that: it is performance-

based with programs that are focused on those needing the highest level of care, it is using a cost-saving approach, and it relies on audits. Additionally, MBHP felt that retaining its role as the state carve-out for behavioral health services would provide stability for those most in need during health care reform.

MBHP explained that it keeps overhead costs low and is consumer-focused. MBHP's contract has been constructed to align performance incentives to achieve the Commonwealth's goals. Any unspent dollars are returned to the state. 91.7% of their funding goes towards providing direct service, whereas 7.2% is spent on administration and 1.1% is spent on performance incentives. MBHP concluded by asserting that retaining their services will ensure that people with serious mental illness will not have their care disrupted during the transition in how health care is delivered in Massachusetts.

Health Plans
Each of the Health Plans [Neighborhood Health Plan, Fallon Community Health Plan, Beacon Health Strategies, Network Health (Cambridge), HealthNet (Boston Medical Center)] testified to the importance of integrating medical and behavioral health care. HealthNet and Network Health testified that their behavioral health services are provided as part of a fully integrated model – with no carve out. Both Network Health and HealthNet testified that there were many fewer members of the Primary Care Clinical (PCC) Plan who have intensive behavioral health care needs.

However, in their testimony two of the plans, Neighborhood Health Plan (NHP) and Fallon Community Health Plan (Fallon), also supported an integrated model of care but reported that the integration could happen even if behavioral health services were carved out. Both NHP and Fallon reported working with Beacon Health Strategies, a specialty managed care organization that provides behavioral health services to NHP and Fallon members. In testimony from each of these organizations, they discussed various forms of integrated care in the context of their carve-out (e.g. co-location of staff, etc.)

Each of the health plans discussed their high ratings on the HEDIS scale and other best practice measurements.

Researchers
The Committee heard from a number of researchers who had conducted evaluations of MassHealth managed behavioral health care programs.

Richard Beineke, Suffolk University/Donald Shepard, Brandeis University
Both of these experts in the field of health policy testified in favor of preserving the carve-out as it has lowered costs and increased quality and access. They reported that the state carve-out is one of the most studied managed care programs in the country. Studies have demonstrated that it serves an unusually high number of people with severe mental health and substance abuse issues. Testimony from Dr. Beineke indicated that the carve-out (MBHP) had increased quality and access, reduced health care expenditures, increased quality improvement and oversight activities, pioneered performance incentive

contracting and has led to more creative programming that better serves consumers and family members,.

Dr. Shepard also provided testimony that was specifically focused on the research he did in a report entitled, "*MassHealth Behavioral Health Care: Comparison between the Behavioral Health Carve Out and Managed Care Organizations*" in January 2006. Shepard reported that since the creation of MassHealth in 1992, members have generally had a choice to receive care from two arrangements: they can belong to an MCO or participate in the PCC plan for general health and receive behavioral health through a carve-out. The analysis of the data led Shepard to conclude that the arrangement in place at the current time for providing behavioral health care services to MassHealth enrollees is effective and should be maintained.

Dr. Richard Frank, Harvard University
Dr. Frank presented testimony as an expert in Health Economics who has 26 years of experience in researching economics and mental health care. Dr. Frank indicated that mental health and substance abuse services face unique pressure in competitive insurance markets. He noted that being known as the "best mental health plan in town", as MBHP is, will draw some of the most expensive enrollees. There are benefits and drawbacks to the use of behavioral health carve-outs. Among the features of MassHealth behavioral health carve-out programs that determine their success are the statute and administration of the contract with the specialty carve-out vendor. In the case of MBHP, DMH has contracted in a manner that has produced a balance of the state's financial interests and care of a very vulnerable population. Due to the state managing the contract in a way to have the state and contractor's interest be similar, it has created a strong argument for using the carve-out approach. He stated that there are some disadvantages to the carve-out as well such as additional administrative costs, difficulties in coordinating care between general Medicaid and specialty behavioral health providers, and incentives to cost shift on the pharmacy services. But, he concluded that Massachusetts has been a model for the nation for 15 years and continues to work on improving the carve-out.

Advocacy and consumer groups
Each of the advocacy and consumer groups discussed how the carve-out has impacted their organizations and responded to the needs of the people they represent. Overall, these organizations were satisfied with the carve-out and argued for preserving it. There was concern that the state is looking to dismantle the system and therefore disrupt care for many children, adults, and families. They argued that, although a change might be immediately more cost effective, there would be additional costs due to increased hospitalizations, emergency room visits, arrests, incarcerations, etc. They underlined the need for consumers to have choice.

Mary Lou Sudders, Executive Director of the Massachusetts Society for the Prevention of Cruelty to Children and the former Commissioner of the Department of Mental Health, discussed the importance of maintaining and expanding the role of the Commissioner of DMH. She expressed concern that this role is being compromised by MassHealth, which is a purchaser, not the authority over behavioral health. She

suggested that there should be language in Chapter 19 of the Massachusetts General Laws to set the standards and specifications for oversight of all behavioral health.

The **Parent/Professional Advocacy League** highlighted MBHP's efforts to address the issues around "stuck kids" and the **Clubhouse Coalition** applauded MBHP for its funding and support.

The **Massachusetts Organization for Addiction Recovery** argued for a substance abuse carve-out in insurance plans.

Susan Fendell of the **Mental Health Legal Advisors Committee** rejected the idea that the state should contract with either MBHP or the MCOs but rather argued that the public sector should take over the work currently performed by the carve-out.

Children's Mental Health

Department of Mental Health

Commissioner Beth Childs and Assistant Commissioner Joan Mikula reported that mental health problems affect one in ten children and states spend nearly $1 billion every year on medical costs associated with suicide. Suicide is the third leading cause of death among 15-24 year olds. In addition, 65% of boys and 75% of girls in juvenile detention facilities have at least one mental health disorder, and a US Department of Education report found that 50% of children (14 and older) with such disorders drop out of high school.

Dr. Childs explained that Massachusetts responded to these statistics in 2002 when the legislature established the Mental Health Commission for Children (the "Commission"). The original mission of the Commission was to examine the issue of "stuck kids," but the focus became broader once the Commission started to meet.

Dr. Childs further explained that the Department of Mental Health applies the following principles in providing treatment and care for children and adolescents:

1. Appropriate care for all
2. Mental health parity
3. Family-centered care
4. Evidence-based practice
5. Prevention, health promotion, and wellness

Young people need programs that are appropriate for their age group and the Department of Education should be included in planning any programs. The DMH noted that there must be a close partnership between stakeholders, families, providers, communities, and children and adolescents.

In response to a question from Chairwoman Balser about what more should be done, the DMH noted that there need to be more programs for transitional aged youth (those in the 16-25 year range); families need to be more involved. In addition, services in the community should be strengthened as they are preferable to services in institutions. DMH went further to explain that the 16-25 transitional aged youth is the time period for the on-set of most major mental illnesses. With 45% of children with mental illness being served by DMH, private insurance is not meeting their needs.

Massachusetts Chapter of the American Academy of Pediatrics

Dr. Walter Harrison testified as the chair of the Children's Mental Health Task Force of the American Academy of Pediatrics and a member of the Governor's Special Commission on Children's Mental Health. His testimony focused on three areas: mental health and developmental screening; the proposed movement of patients from the PCC plan to Medicaid MCOs; substance abuse in children and adolescents. Dr. Harrison noted that one of the main recommendations from the Governor's Commission was to formally screen children covered under MassHealth for developmental and mental health problems.

The importance of early screening includes:

- Problems are caught earlier and treatment is less costly
- Private health plans are already reimbursing for this
- Elimination of stigma
- Integration of medical and mental health care
- Estimates from the Surgeon General indicate that 20% of children have significant psychosocial emotional problems
- Current informal screening identifies only 6% of mental health problems in children

Dr. Harrison indicated that this type of early formal screening should result in a reduction in cost specifically in the areas of special education, emergency care, detention placement, psychiatric hospitalizations, and adolescent substance abuse.

Dr. Harrison also mentioned concern about the proposal to move young people from the services they are receiving through the Massachusetts Behavioral Health Partnership (MBHP), as the carve-out for the State's PCC plan and also for the Department of Social Services (DSS) and Department of Youth Services (DYS). Dr. Harrison noted that whatever course the state takes with respect to behavioral health procurement, pediatric screening should be at the core of medical care.

Dr. Sean Palfrey also presented testimony on behalf of the pediatricians. He stressed that Massachusetts needs to work toward a comprehensive child mental health system. He articulated eight key points for the system. They are:

1. evaluate and treat infants and children with mental health problems on a medical model
2. identify all children at risk as early as possible
3. incorporate mental health services into early periodic screening detection and treatment
4. incorporate routine screenings and evaluations into all education programs
5. improve communication and coordination of care
6. treat mental illness as a family issue with family-centered programs
7. establish CORE-like evaluations for mental health in schools
8. distinguish mental health and behavioral problems from educational problems – mental health services should be distinguished from special education services

Children's Mental Health Commission
Dr. William Beardslee, co-chair
Secretary Ron Preston, co-chair

The co-chairs of the Mental Health Commission for Children (the Commission) presented testimony on behalf of the Commission. The Commission agreed to a set of core principles that should guide all mental health care for children. These core principles are: appropriate treatment for all; parity between mental and physical health; family centered care; evidenced based practice; universal and timely access to screening;

a focus on prevention; health promotion and wellness; and on the development of appropriate community supports and culturally competent programs.

The Commission co-chairs highlighted two major points:

1. DMH must be the convener and catalyst for children's services and preserve the DMH role over Medicaid services
2. Services must be tailored to each child

Their testimony noted that while 20% of children suffer from mental health problems, autism, and substance abuse, only 4% have behavioral or mental health coverage. To improve this situation they suggested increased funding for Mass Health to cover screening. Another recommendation was to coordinate mental health care in homes, doctor's offices, and schools including screenings and treatment programs. In addition, a CORE style program of evaluation for mental health problems in schools should be established. It was noted that schools expel boys at 5 times the rate of girls and early education can address this problem. In addition, prevention should be promoted for children transitioning to preschool and then public school. Increasing the role of family was also heavily stressed. In addition, a $1.4 million increase in FY'07 to expand MassHealth consultation services for preschool age children as well as support for H. 4582 were recommended. The argument was also made that any money spent on prevention now will save money on treatment later.

At the moment there are too many children in hospital beds. This is in part because hospitals and families find it nearly impossible to navigate among fragmented care. Private insurance will also stop funding for children who still need hospitalization. DYS needs to secure beds for these children. In addition, there are too few pediatric psychiatrists and many primary care physicians do not know how to prescribe psychotropic drugs.

Dr. Beardslee raised a number of other concerns in his testimony. Of those, he noted that the single most important reform was mental health parity, which he explained must be accurately defined. He further noted that designated billing codes must be established and compliance must be subject to oversight by the Department of Mental Health and the Division of Insurance. The Commission members also strongly recommended that payers report coherent and useful data on access to care and prevalence data under the oversight of the same two agencies. Public payers should reimburse for mental health, substance abuse and developmental screenings for children. In cases where a child is involved in multiple agencies, one agency should take the lead in care planning and coordination.

The testimony also made reference to "stuck kids" – children remaining in hospitals or acute care facilities longer than is medically necessary. This was the greatest impetus for the creation of the Commission. Since the issue still exits, the Commission is seeking legislative authorization for a study with the ultimate goal of ensuring that all school age children have access to a responsive educational environment to respond to those with complex needs.

Chairwoman Balser questioned whether there should be some sort of statutory extension of the Commission. Dr. Beardslee indicated interest in extending oversight capacity in implementation of its recommendation and maintaining an advisory role to the Commissioner of Mental Health.

Center for Public Representation

The legal groups who testified were in agreement that the Commonwealth does not offer legally acceptable home-based services and accused the Department of Social Services of not providing in-depth assessments of children's needs. There followed a lengthy discussion of the *Rosie D. v. Romney* lawsuit.

Steven Schwartz, Director of the Center for Public Representation (CPR) provided testimony about the *Rosie D. v. Romney* case, a class action lawsuit brought to compel Massachusetts to provide intensive home-based mental health services that will enable children with severe psychiatric disabilities to receive treatment and support in their homes and home communities. The plaintiffs included eight named children and a class of over 15,000 children throughout the Commonwealth with serious psychiatric and emotional disabilities.

The case was a five year litigation effort which alleged that the Commonwealth violated the federal Medicaid Act as it failed to provide medically necessary care for children by both failing to inform children and their families about services and then failing to provide them. The trial lasted six weeks and included more than thirty witnesses who testified about the effectiveness of home-based services, the state's failure to provide these services, the thousands of children in need and the harm caused by denying treatment.

In a landmark decision, Judge Michael Ponsor ruled that the Commonwealth of Massachusetts is violating the federal Medicaid Act and that as a "result of this failure thousands of Massachusetts children with emotional disabilities are forced to endure unnecessary confinement in residential facilities or to remain in costly institutions far longer than their medical conditions require." The judge noted in his opinion that Massachusetts knows how to provide effective treatment in the community for children with serious emotional disturbance, it has just chosen not to do so except for a few isolated pilot programs serving a small fraction of the children who need this type of care. In short, the ruling stated that the Commonwealth of Massachusetts is engaged in a massive and manifest violation of the federal Medicaid Act.

The Court determined that the parties could work together to design a remedy to the violations of federal law. The Court noted that the Department of Mental Health (DMH) has a network of services for children, but often children are excluded due to funding constraints that are out of its control. So, though DMH does not control the Medicaid dollars it was designated to be the lead agency to develop and implement the remedy in the case.

Mental Health Legal Advisors also provided testimony on the case and children's issues. Both the Center for Public Representation and Mental Health Legal Advisors agreed that:

- DMH should take the lead in developing and implementing a solution.
- The legislature should require periodic reports from Mass Health and EOHHS on negotiations and short-term and long-term proposals
- The legislature should move money being wasted on institutionalization to create monitored, family-friendly, home-based services, noting that currently there is a shortage of community-settings and homes

Another important issue raised by these legal groups is that youths coming through the courts have higher rates of psychiatric illness, yet currently judges order evaluations on only 11% of youths. Services must be provided for emergency suicide threats as well as substance abuse evaluations. In addition, more attention should be paid to whether a youth is competent to stand trial. However, the funding for such programs has remained level since 1998. Because these children often end up in DYS detention centers, the cost benefit is in favor of supporting more early intervention.

Advocacy Groups
These groups stressed that mental health screening, community based treatment, and coordination of care all need to be improved. The core principles that guide all mental health care must include: parity; family centered-care; evidence based treatment or promising practices; universal and timely access to care; the development of appropriate community supports and culturally competent programs.

Massachusetts Society for Prevention of Cruelty to Children
Marylou Sudders, President and CEO of MSPCC and former Commissioner of Mental Health testified that *Rosie D.* is an example of why MassHealth, the public insurer, should never establish mental health policy. DMH role needs to be elevated to set mental health policy. State dollars for children's mental health should not be MassHealth dollars because then only these children will get the services. There is a need for mental health services for all the state's children.

Parent/Professional Advocacy League
Lisa Lambert, Assistant Director of PPAL testified that children with mental health needs are currently in many different state agencies, schools, courts, institutions, etc., and all are funded and operated differently. In addition, many treatments only last 3 to 4 weeks. While services in the community are desirable, it is frustrating when those programs have waitlists or do not offer long enough terms of care. In the end, it is parents who know what treatments and services their children need. The DMH must play a central role in creating solutions and this role should be solidified in legislation. It is important to note that state dollars for children's mental health should not be MassHealth dollars because then only MassHealth children will receive services.

David Matteodo, Executive Director, Massachusetts Association of Behavioral Health Systems, Inc. testified that there are too many "stuck kids" which make it hard for hospitals to treat those who really need to be there. Also he believes that the Department of Youth Services (DYS) needs some secure beds for the youth they serve. The legislature put $300,000 in the budget in the last two years to treat "stuck kids." Private insurance is a big issue with payments being cut off.

Hospitals, Clinics and Researchers
Dr. David DeMaso, Psychiatrist-in-Chief at Children's Hospital Boston testified that over the past 4 years they have invested in school and community-based prevention. Dr. DeMaso recommended that there be targeted state funding to schools for mental health promotion, prevention and treatment programs. Since 95% of children are in the school, it is a logical intervention point for mental health services.

Representative Balser discussed the shortage of child psychiatrists and suggested that it is because they are required to do a 2nd residency after completing their adult training. The additional time and resources can be prohibitive. Dr. DeMaso suggested that pediatricians should study child psychiatry.

Susan Cole, Director of the Trauma and Learning Policy Initiative of MA Advocates for Children and **Representative Alice Wolf** testified that schools should be central to efforts to improve mental health, as they can provide key aspects of what makes a child resilient. Because of this, funding for prevention programs in schools should be increased. Policy makers must examine how to take existing, effective school-based programs and make them available statewide. First, there must be direct state funding to schools for mental health programs; second, we must increase funding to schools to access the expertise of the mental health community; third, the state must engage private insurers; and fourth, delivering children's mental health services should be a local endeavor.

Dr. Joanne Nicholson, Ph.D., Professor of Psychiatry at University of Massachusetts Medical School focused on treatment for parents who suffer from mental illness. Almost ½ of American women and 1/3 of American men meet the criteria for psychiatric disorder at some point in their life. Many are parents and it is therefore affecting millions of children. Parents do not seek treatment because of stigma and fear of losing custody of their children. Children whose parents have untreated mental illness will be less likely to be able to achieve their goals. A related concern is that 80% of parents reported restrictions on contacting their children in residential settings. This is a major problem as parents are central to advancing a child's treatment.

Lynn Hennigan, Director of Services for the Young Child and the Together for Kids Coalition testified that there is a need for early care. For the past 5 years, she has done research in 5 childcare settings and that too many young children are expelled from childcare settings. About 1/3 of children in childcare settings have shown chronically significant behavior problems often related to mental health issues. Massachusetts has the 9th highest pre-kindergarten expulsion rate in the country, but children who receive

intensive care show improved behavior. She asked for support of $1.4 million increase in FY07 to expand MassHealth consultation services for preschool age children.

Additional public testimony highlighted many of the same issue raised above with the greatest emphasis on the lack of needed services and a need to address issues at a much earlier age.

Mental Health and Substance Abuse Services in Prisons and Jails

Department of Corrections

Commissioner Kathleen Dennehy testified that the DOC recognizes the importance of providing mental health treatment to the prisoners in its custody. In addition to Bridgewater State Hospital, which has 95 full-time equivalent (FTE) positions for clinical services, the DOC provides intakes, treatment, crisis intervention and residential treatment units at its 16 other facilities. Though, not all services are available equally at each facility. In addition, the DOC acknowledged that there are often waitlists for addiction treatment and often treatment is not available to inmates until they are within 18 months of their release. Senator Tolman asked if 95 FTEs was sufficient, to which the Commissioner replied that they need more.

DOC noted that they must be better about communicating with the counties. MCI-Concord is the point of entry for all prisoners in the state correctional system, receiving many transfers from the county facilities. There is often miscommunication and prisoners may arrive to the new facility with inadequate mental health information resulting in confusion for clinicians and corrections staff.

When an individual enters the DOC, a comprehensive assessment and suicide screening is conducted within 14 days and a risk reduction plan is created. Everyone with a mental illness is subsequently monitored. According to DOC policy, patients experiencing a mental health crisis are placed in a segregation cell and put on a mental health watch. DOC should systematically study the use of watches, increasing their safe use and diminishing their negative social side effects. Those that have a substance abuse problem are treated toward the end of their sentence, but there needs to be more integration and coordination between mental health and substance abuse treatment. Often mental health providers will not know that an inmate is receiving substance abuse services unless the inmate offers this information.

Representative Balser commented on how almost all of the inmates have an addiction or mental health problem or both and is concerned that the substance abuse treatment was only offered at the end of their sentence. The Commissioner said that substance abuse treatment is most effective as the person gets closer to leaving prison. However, Representative Balser noted that is a different view than that of addictions specialists who describe addiction as a chronic illness that needs ongoing treatment. In response, Commissioner Dennehy cited limitations of what is available, and described waiting lists for services. She described the recovery programs as popular, and as having a waiting list. Representative Balser asked if there are waiting lists for other medical conditions and was told that may have to wait for specialists or dentists.

Current caseloads for mental health professionals within the DOC are greater than the recommended 30-35 prisoners per 1 full-time employee. Clinicians also face barriers to effective treatment due to the environment of treatment sessions. Group treatment is infrequently used due to limitations on physical space and equipment, which prevents seeing patients in confidential and safe areas.

Segregation of prisoners with mental illness is another big issue. According to DOC policy, if a clinician indicates that an offender is not appropriate for segregation, the offender will not be sent unless there is a compelling reason from the Superintendent. However, many clinicians have indicated that the culture does not support them pushing back.

There must be more attention to discharge planning and re-entry. DOC must also work with other agencies and the community to design re-entry plans for mentally ill inmates returning to the community. In an effort to accomplish this, DOC has partnered with Department of Medical Assistance to provide MassHealth insurance cards upon discharge.

Harshbarger Commission (Mental Health Panel)

Dr. David Powers, who served as the DMH representative on the panel, provided testimony.

The Health and Mental Health Review Panel of the Harshbarger Commission was established in response to the stipulations of the Executive Order creating the Commission. The twenty-four member panel was divided into four subgroups which considered the following specific issues: 1) the scope of medical, pharmacological, dental, and mental health services provided to inmates; 2) the gender-specific medical and mental health needs of the female population; 3) services provided at Bridgewater State Hospital and the Massachusetts Alcohol and Substance Abuse Center; and 4) services provided at Lemuel Shattuck Hospital.

Dr. Powers explained that over a five month period the panel members reviewed numerous documents, toured correctional facilities, observed operations, reviewed medical records, and conducted focus groups with providers, inmates, correctional officers and DOC administrators. The Mental Health Subgroup was specifically charged with reviewing mental health services in the DOC. Dr. Powers reported that the subgroup was generally impressed with the quality and professionalism of the providers, but thought that investments in the mental health system would help providers and inmates by more effectively dealing with mental illness. The panel believed that their recommendations would improve treatment outcomes and reduce the numbers of mental health crises.

Among the recommendations of the panel/commission are:

- Need for more residential treatment units
- End segregation for inmates with mental illness
- Better training for DOC corrections officers
- Study the use of mental health watches, and provide better facilities for inmates on watches
- Increase staffing and use more group treatment modalities
- Improve communications, transfer of information, and coordination between mental health and substance abuse treatment/services

Legislators
Senator Jarrett Barrios, Representative Kay Khan, and **Representative Michael Festa** are legislators who have focused on prison reform issues as well as the criminalization of the mentally ill. They spoke in support of the Harshbarger Commission recommendations and the best practices that have been identified by the Council of State Government Consensus Report and the American Psychiatric Association.

Department of Mental Health
Commissioner Elizabeth Childs testified in her joint role as both the mental health authority in the state and as part of the Department of Corrections Advisory Council, the body charged with monitoring the implementation of the reforms recommended by the Governor's Commission on Correction Reform.

The Commissioner noted that according to US Justice Department statistics, approximately16% of the population in prison or jail has a mental illness and nearly ¾ of inmates with a mental illness have a co-occurring substance abuse disorder. Inmates should receive access to a continuum of mental health care from the time of classification into the DOC to the time of their release. The Commissioner reiterated her support for the mental health and substance abuse recommendations included in the Governor's Commission on Corrections Reform.

DMH has established partnerships with DOC to review mental health examinations in prisons (State Prison Survey Team) and provide re-entry services for inmates with severe and persistent mental illness who are being released into the community (Forensic Transition Team). The MassHealth Behavioral Health, a division of DMH, screens ex-offenders for physical and behavioral health needs and coordinates community-based services through a project called Healthcare Access Protocol.

Contracted Vendors for Corrections behavioral Health Services
UMass Medical School
Dr. Kenneth Appelbaum and Dr. William Ferguson testified on behalf of UMass Medical School, as the provider of mental health services within the Department of Corrections (DOC). According to both doctors, the extent of mental health issues within DOC is huge and while UMass has helped to address it there are significant basic unmet needs as the prevalence of mental health and substance abuse needs of inmates has steadily increased for decades.

They testified that many inmates have co-morbid medical and mental health problems; 80% of inmates have substance involvement prior to incarceration and 27% of men have Hepatitis C. Medical conditions increase the cost of treatment and present safety issues; in spite of this, many correctional institutions either do not have infirmaries or if they do it is not designed for effective care. Also, DOC is restricted from using Methadone and Buprenorphine which create acute withdrawal and less effective treatment.

Coordination efforts of mental health services vary from facility to facility. There needs to be both effective mental health treatment and effective security within correctional institutions. The UMass Medical School Correctional Health program includes: community mental health treatment model; multidisciplinary mental health treatment teams; psychosocial rehabilitation services; continuing education programs for DOC based staff; training programs in psychiatry; psychology and social work. However there needs to be an increase in the budget for more staff, higher salaries for staff and expanded rehabilitation and specialized programs for mentally ill inmates in segregation.

Spectrum Health Systems

Charles Faris testified on behalf of Spectrum Health, provider of substance abuse services for the corrections system. Since 1993, DOC has contracted with Spectrum to provide substance abuse treatment, anger management, relapse prevention services and discharge planning. Spectrum has expanded its services to all 17 institutions and the DOC provides funding for 643 residential treatment beds. However, only 9% of the 7,500 inmates needing treatment can be served through Spectrum's residential program due to the limited number of funded beds. In addition, only non-residential substance abuse programming is available at minimum security institutions. The following recommendations will ensure further progress: more funding for discharge planning and to the DPH's Bureau of Substance Abuse, an increase in residential and non-residential treatment at DOC facilities and the designation of an entire DOC facility for substance abuse treatment.

Sheriffs

Hampden Sheriff Michael Ashe

Middlesex Sheriff James DiPaola

Sheriff James. M Cummings, President of the MA Sheriffs Association

According to the Sheriffs and Sheriffs Association, the county correctional system has become an expensive and inefficient treatment provider for the mentally ill because the community does not have the resources to properly assist these people. The courts, community and criminal justice system should work to divert more low level, non-violent mentally ill offenders through proper evaluation and treatment. Additional clinicians and mental health staff should be hired in order to create more opportunities for group and individual counseling sessions. Mentally ill inmates should have a discharge plan in order to reduce the chance of them recidivating.

In Hampden and Middlesex Counties, the Sheriffs operate Regional Mental Health Emergency Stabilization Units which provide short term, intensive psychiatric evaluation and treatment to mentally ill inmates in a safe and structured environment. This program has substantially reduced the amount of transfers to Bridgewater, which in turn resulted in a $43 per day per inmate savings.

The Sheriffs' recommendations include: need more diversion of low level nonviolent offenders, county jails should receive appropriate funding for mental health services, need for comprehensive plan for all mentally ill inmates so there is a continuity of care, and more money for comprehensive medical services is needed.

Massachusetts Correctional Legal Services
There are four primary causes underlying Massachusetts' prison mental health crisis: lack of specialized housing units for the mentally ill (RTUs), lack of proper training and selection of correctional staff, lack of mental health staffing, and there is not enough coordination between correctional and mental health staff. There is only one 56-bed RTU available for level 5 prisoners, who only make up 7% of the population. Correctional staff only receives 2 hours per year of training to deal with mentally ill prisoners, which is solely focused on suicide prevention. In the correctional staff manual, only suicide is discussed in detail and it emphasizes the manipulative behavior of inmates who manifest this through "acting out" and "suicidal gesturing". Thus, psychiatric behaviors become punishable offenses. Mental health professionals are spread extremely thin, with high caseloads, lack of support personnel and inadequate working and treatment space. Currently mental health professionals are given no authority to make or affect decisions affecting classification, discipline, housing and roommate assignment.

National Alliance for the Mentally Ill of Massachusetts
DOC must educate corrections officers on the nature of inmate behaviors under stress. Suicide attempts and self-mutilation need attention. Also, people with mental illness need to be diverted from the criminal justice system. More programs like Framingham Jail Diversion are needed. The Framingham Jail Diversion Program has been running successfully for 3 years.

National Association of Social Workers
Gary Bailey, President of the NASW, testified that social work can be a key factor in addressing recidivism rates. Social workers can provide counseling, education and advocacy services in correctional settings and can assist in the development and implementation of rehabilitation programs.

Family Members of Inmates
Family Member of Nelson Rodriguez – Nelson struggled with mental illness and he bounced between DSS and DMR. He was placed in a maximum security prison, and where he was stuck in a "hole" with no fresh air. He killed himself in a segregation unit at Cedar Junction. There is a need for more training for corrections officers to spot signs and symptoms of mental illness, and there should be special places in prisons to diagnose mental illness. He was 26 when he died. He had asked to see mental health staff but was denied his request. He had warned them that he would hang himself.

Kristin, Sister of an individual in jail – Her brother is in and out of segregation. Each time he is put in a segregated cell he hurts himself or attempts suicide. He has put things in his eyes. She is concerned that he is not getting help; he is just sent back and forth. She received a letter from Bridgewater that they did not find anything wrong with him after the assessment. He was on a mental health watch for 70 days and she had no contact with him. He gets so frustrated being in the segregated cell, so he will tell them he is ok to leave, but then he starts cutting himself again. Her biggest fear is getting a call that he committed suicide. She just wants him to be rehabilitated. He told his correction officer that he might commit suicide, and the correction officer said "go ahead

Richie and hang yourself." He should either be at Bridgewater or getting better services. When he cuts himself he gets a disciplinary report and is sent to segregation. Representative Balser told Kristin that Representative Rushing has filed legislation to prohibit disciplinary action in response to self harm.

Ron Robinson, Son is incarcerated at Cedar-Junction – His son was sentenced in 1998 and he has lost hope. He was mentally normal in 1998 but after years of physical and mental abuse at the hands of correctional personnel, he no longer is. He is treated like an animal, and then he turns into an animal and is punished for it. The system is designed to blame the victim. Correctional staff needs to have training to recognize behavior of mentally ill persons. Lockdown should not be the answer for all institutional infractions. After 5 years of asking questions about son, has finally received permission from UMass for his son to sign an order to get sensitive medical information. It should not take 5 years. He had to write a letter to the parole board to beg them to evaluate him so that he could be referred to a mental health facility upon release. DOC is refusing to refer his son to a mental health facility.

Frances Armstrong, Aunt of Andrew Joseph Armstrong – Andrew killed himself. It was from treatment in prison and drugs. He did not do drugs but started doing heroin in prison. How did he get it? Bridgewater should contact families. Families can tell them the diagnosis.

After the testimony of family members of inmates, Commissioner Dennehy offered to arrange to meet with them to address their concerns.

Mental Health Parity

Department of Mental Health

Dr. Elizabeth Childs testified that the primary goal of the parity law was to provide access to services. The disease burden of mental illness is greater than the disease burden of all cancers. The total economic burden of mental illness was $83.1 billion in 2000. The Commissioner noted that the Commonwealth has seen the benefits of the mental health parity law. As the impact of the parity law in Massachusetts is examined, it should be noted that the Massachusetts law is not the only model for parity. A number of states have broader lists of covered diagnoses and some include substance abuse, which Massachusetts does not.

Representative Balser stated that in 2000 she and other legislators supported going the way of Vermont with full parity but that option did not prevail as the legislature went for a middle ground instead. It was pointed out that the Massachusetts law allows the Department of Mental Health Commissioner to add diagnoses as scientific evidence mounts. To date, no diagnoses have been added to the original list.

Commissioner Childs informed the committee that the federal Substance Abuse and Mental Health Services Administration (SAMHSA) recently published a study of the Vermont parity statute, which is a comprehensive law. The report concluded that the law did not hurt businesses or significantly increase the burden on Vermont's health care system. Among the most significant findings of the SAMHSA study in Vermont were while utilization of outpatient mental health services across the state's two major private insurers increased from 6 to 8 percent after parity, overall costs of mental health services were minimally impacted.

Representative Balser asked if there was research on the connection between expanding parity and reducing state spending. Commissioner Childs said that untreated mental illness has terrible outcomes therefore we want early and effective treatment. She did not know of research to substantiate the hypothesis that if you implement parity in the broadest sense, you effect state spending, but effective, early treatment is good policy.

Department of Public Health and Office of Patient Protection

Testimony was provided by **Karen Granoff**, Director of the Office of Patient Protection, and **Paul Cote,** Commissioner of Public Health, who explained that the Office of Patient Protection (OPP), established in July 2000 is responsible for regulating a health plan's internal appeal process, administering the external appeal process and interpretation and posting of data. The OPP does not apply to Medicare, Medicaid/MassHealth, Federal Employees, employer self-funded plans or any health plan not issued within the state.

Director Granoff explained the mechanics of the grievance process. It begins with an initial adverse determination from a health plan. An internal appeal is filed with the health plan and if the internal appeal is denied, the member may file an external appeal with OPP. To be eligible for external review, the member must be fully insured, the health plan must be MA issued and the requested service cannot be specifically excluded from coverage. Since OPP was established in 2001, appeals related to behavioral health

services are the most prevalent. For example, in 2005 they accounted for 50% of all appeals. Disagreements about medical necessity are the primary reason for OPP contacts.

A number of the Committee members asked questions about the appeals process, particularly the disproportionate number of appeals in behavioral health. Director Granoff indicated that most of the appeals were regarding inpatient mental health and that 50% were overturned within 48 hours. There was also some discussion about how information about OPP is made available to people in the state given a low number of appeals. Some Committee members expressed concern but OPP indicated that the appeals are low because the health plans know the rules and follow them.

Bureau of Managed Care, Division of Insurance (DOI)
Nancy Schwartz, Director of the Bureau of Managed Care (Bureau), provided testimony on behalf of the Bureau, which is responsible for monitoring health carriers, licensing brokers, reviewing products, enforcing health insurance laws and ensuring that carriers provide mental health benefits under the mental health parity law. Health carriers must submit any "material changes" to their contracts, policies, etc. to the Bureau so they can review for compliance with the parity law. Carriers are notified of any deficiencies and must come into full compliance before distributing the materials. Director Schwartz reminded the Committee members that the state's mental health parity law does not apply to self-funded single employer plans or, Medicare because of federal exemptions. The Bureau of Managed Care's monitoring of carriers includes a review of all products offered and materials distributed. Also, documents are carefully reviewed after the parity statute took effect and if a plan was not in compliance, it had to be changed. Health plans must submit any material changes to the Bureau of Managed Care. Carriers are notified of any deficiencies and must come into compliance before distributing the materials.

Since the inception of the mental health parity law, the Bureau has worked with DMH to clarify benefits and provide ongoing assistance to carriers. The Bureau has reminded carriers that their networks must include a full range of providers, reiterated minimum standards for provider network adequacy and asked carriers to have procedures to help the insured in scheduling appointments.

Massachusetts Psychiatric Society
The Massachusetts Psychiatric Society (MPS) identified several problems with the scope of the parity law. First, parity covers only the designated "biologically-based" disorders; this distinction is widely recognized as arbitrary. Second, administrative mechanisms can be used to defeat the purposes of parity by discouraging patients from utilizing its services. Third, the definition of "medically necessary" treatment is subject to varied interpretation by the insurance companies. Fourth, since some insurers "carve-out" the mental health care they provide to MCOs the carve-outs are only responsible for mental health claims and have no incentive to facilitate more efficient treatment. These carve-outs currently receive no oversight from the state.

MPS submitted additional documentation providing full explanation of the parity laws from other states along with cost details of some states' approaches. The data shows that

equitable insurance coverage for mental illness is affordable. In addition, their testimony provided three recommendations for improving the current system.

Recommendations:
- Enact full parity for mental illness and substance abuse treatment
- Apply consistent criteria for utilization management
- Legislature must require licensing of mental health "carve outs"

Boston Public Health Commission
Coordination of care is a critical element in providing mental health services and achieving parity for recipients of MassHealth. There are many issues with mental health of children and adolescents that involve different areas including school and home life. To help address these issues, the state must promote and finance coordinated, community-based mental health care.

MA Association of Behavioral Health Systems, Inc.
These groups suggested a number of changes. First, the legislature should pass the Substance Abuse Parity Act. Second, H.3047 must be passed, which would require insurers to defer to clinicians unless there is a preponderance of the evidence that the treatment is not medically necessary. Third, biologically-based illnesses should be covered by the MHPL. Fourth, support for the Patients Rights Process of the Managed Care Act and adequate funding for OPP should be continued.

MA Association of Health Plans
In most cases that go to the appeals process, the problem has to do with the type of care rather than if treatment is necessary. The problem of networks is very complex and health plans are legally responsible for treatment decisions to the DOI. Further, when there is an appeal pending, the member will continue to receive benefits until the appeal is resolved. They oppose changing the mental health parity law.

MA Psychological Association (MPA)
Dr. Elena Eisman testified on behalf of MPA and noted that the original parity bill was filed by the Mental Health Coalition. She believes that the legislature passed ¾ of the bill. She echoed other testimony objecting to the biological vs. non-biological distinction and pointed out that different insurers interpret the list of diagnoses differently. Also, she asserted that the definition of "medical necessity" is a concern. An additional issue she cited is the interface between schools and behavioral treatment. She urged passage of a full parity bill.

Advocacy Groups
Representatives from the **National Alliance for the Mentally Ill (NAMI)** testified about two primary concerns with the parity law in its current form; the lack of full parity coverage for post-traumatic stress disorder; and the issue of who determines medical necessity. NAMI strongly advocated for the legislature to pass full parity.

Health Law Advocates (HLA) testimony suggested that the legislature review four issues:

- Legislature should require DMH to promulgate regulations in a reasonable time period (i.e. 3 months)
- When insured individuals turn 19, insurers automatically drop them from coverage which may violate the mental health parity law
- What constitutes a meaningful list of network providers for HMOs and what constitutes a reasonable effort to "exhaust in-network providers" for those individuals seeking mental health benefits?
- The mental health parity law assessment for private insurers will pay for neuropsychological assessments even when the child or adolescent has a special education plan
    - So neither is paying and the child ends up without services
    - Should amend this section of the law

HLA was also concerned about the implementation of "medical necessity" and who decides, the practitioner or the insurance plan. This particular concern was echoed by representatives of the **Mental Health Legal Advisors Committee**.

National Association of Social Workers provided testimony which included three suggestions on how to improve parity: clarifying problems with issue of medical necessity; better access to timely mental health treatment for people with chronic, major mental illness; and improvements must be made to keep parity up with scientific research, including all biologically-based disorders.

Massachusetts Association of Eating Disorders urged the inclusion of eating disorders under parity coverage. They also indicated that there needs to be greater outreach to doctors, social workers, and other mental health providers to inform them of this law.

Health Education and Learning Program for Black Males presented testimony about the disproportionate impact of PTSD on young black males and therefore the lack of full parity coverage for services. The issue of health disparities by race was stressed.

Physician Testimony
A number of physicians provided testimony including **Donald Wexler, M.D**.; **Roger Pitman, M.D.**, Harvard Medical School, Professor of Psychiatry; and **Dr. William R. Mark**, Bedford Veteran Affairs, Post Traumatic Stress Disorder Coordinator. Their testimony addressed a number of issues.

They report that studies have found that brain function is different in people with PTSD and that there are structural abnormalities in their brains. Despite this, Massachusetts does not consider PTSD a parity psychiatric disorder and people with PTSD have access to just 24 visits a year. It is not fair to practitioners or patients to have visits artificially limited. (PTSD is considered a parity psychiatric disorder in CT, ME, NH, RI, and VT.)

Another issue is that currently benefits are approved one at a time and consumers are not informed of how their benefits are determined. In addition, too many groups are exempted from the MHPL. A further problem is that many poor people are denied access to medication because of formulary prescriptions and unavailability of some medications.

Based on their testimony, these doctors made the following recommendations: programs should be developed that look into funding paraprofessionals; billing costs are far too high and more time should be freed up for direct care; and, there are too many companies, forms, intrusions, and barriers to providing adequate care.

Sub-Committee on Alcoholism

The Joint Committee on Mental Health and Substance Abuse established a Sub-Committee on Alcoholism. House Vice-Chair Elizabeth Malia was appointed to chair the sub-committee.

The mission of the Sub-Committee is to investigate and study the impact of alcoholic abuse and its consequences, including but not limited to: an analysis of current statutes, regulations and policies; an analysis of the availability and access to treatment services, and costs associated with the loss of productivity in employment, traffic fatalities and injuries and law enforcement efforts. The Sub-Committee will also focus on alcohol abuse by minors in an effort to strategize to counteract social and industry pressures on young people to drink; minimize alcohol promotions, advertising, and other marketing strategies employed by the alcohol industry; and to focus on the incidence and impact of underage alcohol consumption and binge consumption by middle school, high school age persons and by students at college campuses. The sub-committee will additionally consider that insofar as a person's initial contact with alcohol further contributes to their use of other substances, it will look at substance abuse more generally. The Sub-Committee considered which substance abuse services were most critical to restore. Since the inception of the Sub-Committee, there have been the following successes:

- Restored $5M in FY07 budget for step-down recovery programs
- Research state policies regarding underage drinking, and it consequences
- Research alcohol advertising and promotions and the effects it has on youth in the neighborhoods in which they advertise
- Review prior alcohol tax legislation and strategize how legislation could be revisited to counter the cost of effect of alcoholism in adults and youth in the Commonwealth
- Collaborated with Suffolk County Jail on research regarding the cost to house an inmate with substance abuse related problems and the effect that has on the overall Commonwealth budget
- Analyzed the number of repeat offenders for substance abuse and how that effect the Commonwealth budget
- Consider the cost to the Commonwealth regarding inmates that are incarcerated that really should be in detox beds, and not imprisoned
- Investigate the substance abuse and alcoholism resources available to communities of color and language, and determine the means that which we could establish more viable resources for these communities most in need

The Sub-Committee focused this first term on research. It plans to continue into the future by expanding its membership to include elected officials outside of the legislature such as sheriffs and other members of the public.

Additional Activities

Substance Abuse Interagency Council

Representative Balser and Senator Tolman represented the Committee on the newly established Governor's Interagency Council on Substance Abuse, which was established by Executive Order #467 (05-05) as part of the Governor's Strategic Plan for Substance Abuse Services in the Commonwealth. The Interagency Council is chaired by the Lieutenant Governor, staffed by an Executive Director appointed by the Lieutenant Governor, and consists of the following members or their designees: the Secretary of Health and Human Services; the Secretary of Public Safety; the Secretary of Elder Affairs; the Secretary of Veterans Affairs; the Commissioner of Public Health; the Commissioner of Correction; the Commissioner of Education; the Commissioner of Parole; the Commissioner of Youth Services; the Commissioner of Mental Health; the Commissioner of Mental Retardation; the Commissioner of the Massachusetts Rehabilitation Commission; the Commissioner of Transitional Assistance; the Commissioner of Social Services; the Commissioner of Health Care Finance and Policy; the Commissioner for the Deaf and Hard of Hearing; the Commissioner for Early Education and Care; the Assistant Commissioner of Public Health for Substance Abuse Services; the Medicaid Director; the Chief Justice of the Juvenile Court; the Chief Justice of the Superior Court; the Chief Justice of the Trial Court; a representative of the Governor's Office; one private citizen who is recovering from substance abuse problems, appointed by the Governor; one member appointed by the President of the Senate; one member appointed by the Speaker of the House; one member appointed by the Senate Minority Leader; one member appointed by the House Minority Leader; and other appropriate representatives as determined by the Governor.

The Council was created to maximize and align available resources, and develop unified statewide strategies to drive changes in substance abuse prevention and treatment systems. This council also brings together the two separate councils for alcohol and drugs that previously existed.

National Council of State Legislatures Briefing

The Committee also worked with the National Council of State Legislatures to sponsor a Legislative Briefing in March 2006 on Performance Measurement in Substance Abuse Treatment. Dr. Mady Chalk, the Director of the Center for Performance-based Policy at the Treatment Research Institute (TRI), discussed TRI's efforts to assist state and local governments in implementing evidence-based changes to their financing, organizational, regulatory, and information reporting polices and practices to improve the quality of clinical care and the delivery of addiction treatment.